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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION,

Petitioner,

vs.

NATIONAL LABOR RELATIONS BOARD, ET AL.,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTIONS PRESENTED

The Health Care Amendments Act of 1974 repealed the exemption of most hospitals from the National Labor Relations Act. In taking that action, Congress admonished the National Labor Relations Board to give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry." App., *infra*, 8a. Ever since, the Board's attempts to apply to the health care industry the same bargaining unit standards it applies in other industries have met with failure. The courts of appeals have rejected the Board's determinations, usually because they failed to give proper weight to the congressional admonition against proliferation. Responding to this "dismal background" (*Id.* at 15a), in 1987 the Board for the first time in its history decided to engage in formal, substantive rulemaking. The rule it issued provides that eight specific bargaining units (and only those units) are appropriate for every acute-care hospital in the country. The questions presented are:

1. Whether the National Labor Relations Board's rule determining that eight specific bargaining units are appropriate for every acute-care hospital contravenes the requirement of Section 9(b) of the National Labor Relations Act (29 U.S.C. § 159(b)) that "[t]he Board shall decide [the appropriate bargaining unit] in each case."

2. Whether the rule is consistent with the Health Care Amendments Act of 1974 and the congressional admonition to "prevent[ ] proliferation of bargaining units in the health care industry."

3. Whether the rule is arbitrary and capricious and not based on substantial evidence insofar as it ignores the critical differences among the more than 4,000 private, acute-care hospitals in the United States.

PARTIES TO THE PROCEEDINGS AND RULE 29.1 STATEMENT

In addition to the parties named in the caption, the following entities and individuals were appellants in the court of appeals and are respondents in this Court:

James M. Stephens
Mary M. Cracraft
Dennis M. Devaney
Clifford R. Oviatt, Jr.*
John C. Truesdale
American Nurses Association
American Federation of Labor and Congress of Industrial Organization
Building and Construction Trades Department, AFL-CIO

* Substituted as a respondent pursuant to Rule 35.3 of the Rules of this Court.

Pursuant to Rule 29.1 of the Rules of this Court, petitioner American Hospital Association states that it has no parent or subsidiary companies (other than wholly-owned subsidiaries).

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STATUTES, RULES & REGULATIONS:

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MISCELLANEOUS:

American Hospital Association ("AHA") petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-16a) is reported at 899 F.2d 651. The opinion of the district court (App., *infra*, 17a-42a) is reported at 718 F.Supp. 704.

JURISDICTION

The judgment of the court of appeals was entered on April 11, 1990. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), and the National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16347-16348 (1989), 29 C.F.R. § 103.30, are set forth at App., *infra*, 43a-46a.

STATEMENT

From 1947 until 1974, most hospitals were excluded from the coverage of the National Labor Relations Act.[1] When Congress amended the law in 1974 to encompass

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[1] Before 1974, the Act excluded nonproprietary (*i.e.*, private, not-for-profit) hospitals. They comprise nearly 83% of all private hospitals. American Hospital Ass'n, *Hospital Statistics* 207 (1989-90 ed.). Public employers, including government-owned hospitals, remain excluded from the Act. 29 U.S.C. § 152(2).

all private hospitals, it specifically instructed the National Labor Relations Board that in carrying out its statutory obligation to "decide in each case" the appropriate unit for collective bargaining, it should give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry." S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). From 1974 until 1987, the Board's hospital bargaining unit determinations repeatedly were rejected by the courts of appeals, usually on the ground that the Board had ignored the congressional admonition against proliferation of bargaining units.

Clearly frustrated by its failure in the courts (App., *infra*, 15a), in 1987 the Board engaged in "the first significant substantive exertion of [its] rulemaking powers." *Id.* at 1a. The rule it ultimately issued provides that eight specific bargaining units are appropriate for all acute-care hospitals regardless of their size, location, or differences in their operation. The petitioner, American Hospital Association, successfully challenged the bargaining unit rule in the district court, which held that the Board once again had failed to follow the congressional admonition. But the court of appeals—following an approach that differed markedly from that of other courts of appeals in health care bargaining unit cases—reversed and upheld the rule.

As the National Labor Relations Board has acknowledged, this case "raises an issue of unusual public importance, for the Rule [at issue] establishes bargaining units for a major segment of the health care industry * * *." Motion for Priority Consideration In Setting Oral Argument at 3. The acute-care needs of this country are served by over 5,500 hospitals. American Hospital Ass'n, *Hospital Statistics* 202 (1989-90 ed.). Over 4,000 of those are private (*i.e.*, nongovernmental); those hospitals account for over 81% of the acute-care hospital beds in

this country. *Id.* at 20, 202. *All of them are directly affected by this case.* Unless the validity of the Board's rule is resolved now, it undoubtedly will be the subject of hospital-by-hospital litigation. Not only would that be tremendously wasteful of the resources of the courts, the Board, the hospitals, and the unions, but more importantly it would disrupt labor relations—and thus the delivery of quality patient care—throughout the nation. It is essential that this Court grant the petition and resolve the important issues it presents rather than allow them to become the subject of prolonged, disruptive and unnecessary labor strife and litigation.

1. As originally enacted in 1935, the National Labor Relations Act covered all private hospitals. But in 1947, as part of the Taft-Hartley Act, Congress amended the definition of "employer" to exclude "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual." 29 U.S.C. § 152(2) (repealed, 1974). The exclusion was seen by its sponsors as necessary to "enable [nonprofit institutions] to keep the doors open and operate the hospitals." II NLRB, *Legis. Hist. of the Labor Management Relations Act, 1947* at 1464 (Reprint ed. 1985).

The Health Care Amendments Act of 1974 repealed the exemption of nonproprietary hospitals.[2] That Act was the

[2] In 1967, the Board reversed its previous position that private, proprietary hospitals were not engaged in interstate commerce and therefore were not covered by the Act. *Butte Medical Properties*, 168 NLRB 266, 268 (1967); *University Nursing Home, Inc.*, 168 NLRB 263 (1967). But because more than 80% of private hospitals are non-proprietary (see American Hospital Ass'n, *Hospital Statistics* 20), that ruling did not lead to much organizing activity among hospital employees. By bringing all private hospitals within the coverage of the Act, the 1974 statute made unionization of the hospital industry possible.

product of a legislative process that lasted two years. In 1972, a House bill that simply would have repealed the hospital exemption failed to make it out of committee in the Senate. The primary Senate opponent of the bill was Senator Robert Taft, Jr. He did not object to extending collective bargaining rights to hospital employees, but believed that the industry warranted special protection "to minimize work stoppages and to insure safe patient care." *Hearings on S. 794 Before the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare*, 93d Cong., 2d Sess. 75 (1973) (hereinafter "*1973 Hearings*").

In 1973, Senator Taft sponsored a new bill (S. 2292) that would have designated four bargaining units as appropriate in all health care institutions: professionals, technicians, office clericals and other nonprofessionals (*i.e.*, service and maintenance employees). *Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974* (hereinafter referred to as "*Leg. Hist.*"), at 457-458. Under the bill, the Board could not approve narrower units without the consent of the employer. *Ibid.* But Senator Taft's bill was opposed as overly rigid and unduly restrictive of the flexibility of the Board to determine health care bargaining units on a case-by-case basis taking into account the particular situation at each hospital. *Id.* at 113-114.

In light of these objections, Senator Taft introduced a compromise bill, S. 3088, that became the Health Care Amendments Act of 1974. *Leg. Hist.* at 462. The bill did not limit the Board's prescribed flexibility to determine the appropriate bargaining unit "in each case" (29 U.S.C. § 159(b)), but the sponsors agreed that the following language should appear in both the Senate and the House Reports (S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974)):

> Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).[3]
>
> [3] By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

That agreed-upon language in the legislative history, known as the "congressional admonition," expresses "Congress' intent that the Board be free to exercise flexibility in dealing with unit determinations on a case-by-case basis." *St. Francis Hospital*, 271 NLRB 948, 951 n. 17 (1984).

2. Following passage of the 1974 Act, the National Labor Relations Board determined the appropriateness of hospital bargaining units in its traditional way: through case-by-case adjudication. But as the court below found—and as the Board acknowledged in its first Notice of Proposed Rulemaking ("NPR I"), 52 Fed. Reg. 25143 (1987)—the Board's efforts were "widely regarded as a failure" (App., *infra*, 15a) and were regularly rejected by the courts of appeals, usually on the ground that the Board had failed to pay proper heed to the congressional admonition. It was against this "dismal background" (*ibid.*) that the Board decided to abandon the flexible, case-by-case approach that had been applauded by the opponents of Senator Taft's first bill and to adopt its own rigid rule.

In *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765 (1975), the Board first considered a hospital bargaining unit in the light of the congressional admonition. The Regional Director of the Board had determined that a unit

of all professionals—rather than the requested unit of registered nurses only—was appropriate. The full Board disagreed, however, and held "that registered nurses * * * are entitled to be represented for the purposes of collective bargaining in a separate unit." *Id.* at 767. But when the Board subsequently attempted to apply this *per se* rule that registered nurses were entitled to a separate unit, the Ninth Circuit denied enforcement. *NLRB* v. *St. Francis Hospital of Lynwood*, 601 F.2d 404 (9th Cir. 1979).

The Ninth Circuit carefully considered the legislative history of the 1974 Act, including the congressional admonition, and held that although a unit of registered nurses might be appropriate in some cases, the Board could not establish a presumption that such units are appropriate and thus dispense with the required case-by-case consideration (601 F.2d at 416):

> This is not to say that a determination of a bargaining unit composed exclusively of registered nurses can never be valid. Rather, the problem lies in a rule that such a unit is always valid and its concomitant procedural quirk which excludes any consideration of evidence to the contrary. What is necessary is a demonstration, not a mere presumption, of a disparity of interests between registered nurses and other hospital employees.

Several other courts of appeals also rejected bargaining unit determinations when the Board attempted to apply presumptions that certain bargaining units were appropriate or otherwise failed to consider in each case whether the proposed unit would cause "proliferation." See, *e.g.*, *Long Island Jewish-Hillside Medical Center* v. *NLRB*, 685 F.2d 29, 34-35 (2d Cir. 1982) ("single-facility presumption * * * in the health care context" is inappropriate in light of the congressional admonition); *NLRB* v. *Mercy Hospital Ass'n*, 606 F.2d 22, 27-28 (2d Cir. 1979), cert. denied, 445

U.S. 971 (1980) (maintenance unit rejected because Board failed to conduct "an independent evaluation" of whether it would contribute to proliferation "in this particular hospital"); *St. Vincent's Hospital* v. *NLRB*, 567 F.2d 588, 592-593 (3d Cir. 1977) (certification of separate unit of licensed boiler operators failed to heed the admonition); *NLRB* v. *Frederick Memorial Hospital, Inc.*, 691 F.2d 191, 194 (4th Cir. 1982) (separate unit of registered nurses requires specific explanation of how the unit comports with the admonition); *NLRB* v. *West Suburban Hospital*, 570 F.2d 213, 216 (7th Cir. 1978) (Board failed to show how "its unit determination in this case implemented or reflected th[e] admonition"); *NLRB* v. *HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 809-812 (9th Cir. 1982) (Kennedy, J.) (Board improperly certified separate unit of registered nurses without evaluating whether unit would lead to proliferation; Board has "ignored a controlling legal standard" and has "openly adopt[ed] a posture of noncompliance with the will of Congress"); *Beth Israel Hospital & Geriatric Center* v. *NLRB*, 688 F.2d 697, 698-699 (10th Cir. 1982) (admonition precludes use of presumption that a bargaining unit is appropriate; Board must find in each case that the "units will not lead to undue proliferation at [the particular] health care facilities"); *Presbyterian/St. Lukes Medical Center* v. *NLRB*, 653 F.2d 450, 457 (10th Cir. 1981) (reliance on presumption that a unit of registered nurses is appropriate violates the admonition).

3. The Board's "dismal record" in the courts of appeals led it to revive its long-dormant rulemaking powers.[3] Find-

[3] In 1984, the Board reconsidered its approach to hospital bargaining units. In *St. Francis Hospital*, 271 NLRB at 953-954, it issued a new rule based on a "disparity of interests" standard that, in the words of the Board's Chairman, "as a practical matter allows

(Footnote continued on following page)

ing that "[t]hirteen years and many hundreds of cases later, the Board * * * [is] no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974" (NPR I, 52 Fed. Reg. 25143), the Board concluded that it could achieve greater "judicial and public acceptance" (*id.* at 25144) of its approach to hospital bargaining units if it engaged in rulemaking to determine in advance what units were appropriate. The Board proceeded not merely to establish general guidelines, but to issue a rigid rule that eight designated bargaining units (and only those eight units) would be appropriate for every acute-care hospital in the United States, regardless of differences in size and operation. "We have decided not to make the units only 'presumptively' appropriate, because one important advantage of rulemaking is the certainty it offers." NPR I, 52 Fed. Reg. 25145.

Although the original Notice of Proposed Rulemaking distinguished between large and small facilities and provided for only six bargaining units in large hospitals and four units in small hospitals (52 Fed. Reg. 25149), the Board's final rule provides that "[e]xcept in extraordinary circumstances," the following eight "shall be appropriate units, and the only appropriate units" for all acute-care hospitals (Final Rule, 54 Fed. Reg. 16347-16348 (1989)):

[3] *continued*
for only four units—professionals, technicals, other nonprofessionals and guards." Stephens, "The NLRB's Health Care Rulemaking: Myths versus Reality," *reprinted in* N. Metzger, ed., *Handbook of Health Care Human Resources Management* 405, 409 (2d ed. 1990). However, the new rule was rejected by the District of Columbia Circuit, which held (against the weight of the circuits) that the Board had paid *too much* attention to the congressional admonition. *International Brotherhood of Electrical Workers* v. *NLRB*, 814 F.2d 697, 714-715 (D.C. Cir. 1987). That decision was "the straw that broke the camel's back and prompted us to undertake rulemaking." Stephens, *supra*, at 409. See also NPR I, 52 Fed. Reg. 25143.

(1) All registered nurses.
(2) All physicians.
(3) All professionals except for registered nurses and physicians.
(4) All technical employees.
(5) All skilled maintenance employees.
(6) All business office clerical employees.
(7) All guards.
(8) All [other] nonprofessional employees * * *.

The Board made it quite clear that the "extraordinary circumstances" exception was to be extremely narrow. The Board put hospital employers on notice that it would not consider additional evidence or arguments that a particular hospital varied from the norm even if the variation is "highly unusual." Second Notice of Proposed Rulemaking ("NPR II"), 53 Fed. Reg. 33932-33933 (1988). "To satisfy the requirement of 'extraordinary circumstances,' a party would have to bear the 'heavy burden' to demonstrate * * * the existence of * * * unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field." *Id.* at 33933. The Board specified a long list of factors that it would not even consider as possible extraordinary circumstances.[4]

[4] NPR II, 53 Fed. Reg. 33932. The list includes: "(1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of 'team' care, and cross-training of employees; (3) the impact of nation-wide hospital 'chains'; (4) recent changes within traditional

(Footnote continued on following page)

4. Petitioner American Hospital Association filed suit challenging the rule in the United States District Court for the Northern District of Illinois. On July 25, 1989, the district court held that the rule was invalid and issued a permanent injunction barring its enforcement. App., *infra*, 42a. The court "left for another day" (*id.* at 36a) the question of whether the Board's rule was precluded by the requirement of Section 9(b) of the Act that it determine the appropriate bargaining unit "in each case." 29 U.S.C. § 159(b). But it held that "[a] rule which designates an absolute number of appropriate units and mandates a particular division of the workforce * * * encourages, and perhaps coerces, fragmentation of the labor force" and thus contravenes the congressional admonition. App., *infra*, 41a-42a. The court thus found it unnecessary to reach AHA's claim that the rule was arbitrary, capricious and not supported by the evidence.

The court of appeals reversed. Citing this Court's decision in *Heckler* v. *Campbell*, 461 U.S. 458, 467-468 (1983), the court of appeals held that the "in each case" requirement of Section 9(b) did not require case-by-case determination of bargaining units. The court also held that the rule was not precluded by the congressional admonition. Although it found that the admonition was entitled to "consideration," the court held that Congress was concerned with "finer divisions of the health-care work force than attempted in the rule under challenge." App., *infra*, 14a.

The court of appeals also rejected AHA's claim that the rule was arbitrary and capricious particularly insofar as it failed to distinguish between "hospitals of different sizes

[4] *continued*
employee groupings and professions, *e.g.* the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building."

and missions in different locations" (App., *infra*, 14a). The court criticized the hospital industry for failing to propose an alternative to the rule, not "respond[ing] constructively" to the Board's proposal of a six-employee minimum size for bargaining units, and "opposing a proposed distinction between hospitals having more than one hundred beds and hospitals having fewer." *Ibid.* Without discussing any of the evidence in the record that the Board claimed supported its rule, the court below held that the rule was not arbitrary. *Id.*, at 14a-16a.

On May 2, 1990, the court of appeals granted AHA's motion to stay the issuance of the mandate pending the outcome of the petition for review in this Court.

REASONS FOR GRANTING THE PETITION

Even though the National Labor Relations Board, the AFL-CIO, the American Nurses Association, and the American Hospital Association disagree over the validity of the Board's hospital bargaining unit rule, they all recognize the enormous importance of this dispute and the far-reaching effects that the rule will have on American hospitals, their employees, and the unions that seek to represent those employees. Unless this Court grants the petition and determines whether the Board's rule is valid, it will inevitably be challenged on a hospital-by-hospital, bargaining unit-by-bargaining unit basis throughout the country. That would involve a tremendous waste of the resources of the courts, the Board, and the parties to each dispute. More importantly, it would exact a heavy toll on hospital labor relations and would thus endanger the delivery of quality patient care.

I. The Court Of Appeals' Decision That The Board's Rule Is Not Inconsistent With The "In Each Case" Requirement Of Section 9(b) Is Incorrect And Contrary To The Interpretation Of This Court And Other Courts Of Appeals

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), directs the Board to determine the appropriateness of bargaining units "in each case." As this Court has noted, the language of the statute reflects the diverse organizational needs and desires of employees and the greatly varying organization and operation of employers:

> Wide variations in the forms of employee self-organization and the complexities of modern industrial organization make difficult the use of inflexible rules as the test of an appropriate unit. Congress was informed of the need for flexibility in shaping the unit to the particular case and accordingly gave the Board wide discretion in the matter. * * * The flexibility which Congress thus permitted has characterized the Board's administration of the section and has led it to resort to a wide variety of factors in case-to-case determination of the appropriate unit.

NLRB v. *Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944). The Court has thus recognized that the Board must exercise flexibility in determining bargaining units according to the facts of each particular case. *NLRB* v. *Action Automotive, Inc.*, 469 U.S. 490, 494 (1985); *Packard Motor Car Co.* v. *NLRB*, 330 U.S. 485, 491 (1947).

For over 50 years—until it issued the rule at issue in this petition—the Board fulfilled its statutory obligation by determining bargaining unit questions on an individual, case-by-case basis. That is still the way the Board conducts bargaining unit determinations for all employers *other than acute-care hospitals*. As dissenting Board Member Wilford W. Johansen observed, the Board's rule

disregards the plain meaning of the statute and is inconsistent with the interpretation of the "in each case" requirement rendered by other courts of appeals. 54 Fed. Reg. 16347.

1. In its rulemaking and before the court of appeals, the Board acknowledged that Section 9(b) requires individual, case-by-case determination of bargaining unit appropriateness, but argued that the "in each case" requirement does not preclude it from adopting rules of general application. Final Rule, 54 Fed. Reg. 16338; NLRB Ct. App. Br. at 20-22. We agree that the Board could adopt through rulemaking general principles to guide the required case-by-case determinations, but the rule at issue in this petition does not merely establish general principles or rebuttable factual presumptions. By its express terms, the rule is intended to preclude any meaningful case-by-case evaluation by providing that the eight designated bargaining units "shall be appropriate units, and the only appropriate units" for acute-care hospitals "[e]xcept in extraordinary circumstances." App., *infra*, 44a. The Board made it quite clear that it views the "extraordinary circumstances" exception as so narrow as to be illusory. The Board issued a long list of factors that it would not even consider as potential extraordinary circumstances. See note 4, *supra*. And it warned that "[t]o satisfy the requirement of 'extraordinary circumstances,' a party would have to bear the 'heavy burden' to demonstrate * * * unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field * * *." *Id.* at 33933. The Board expressly rejected the notion that it simply was establishing presumptions that those eight units were appropriate. Final Rule, 54 Fed. Reg. 16338-16339; NPR I, 52 Fed. Reg. 24145.

If, as we believe, Section 9(b) requires meaningful, individual determinations on a case-by-case basis, there can be no question that the Board's rule violates that requirement. The Board's claim that each case would receive an individual hearing is nothing more than an absurd pretense: the Board would not admit any facts about the size, location, or operations of the particular hospital but instead would routinely determine that the eight designated units are appropriate in each and every hospital. The Board has established not merely a rebuttable presumption of fact, but a presumption of law that applies even when the facts are to the contrary.

2. The "in each case" language can hardly be regarded as having no independent significance. The original draft of Section 9(b) as submitted by Senator Wagner contained all of the present language *except* the words "in each case"; those words were added quite deliberately, by amendment, and were intended to carry their plain meaning. The House Report that accompanied the version of the bill that added the "in each case" language explained that the decision of whether a bargaining unit is appropriate "is obviously one for determination *in each individual case* * * *." H.R. Rep. No. 969, 74th Cong., 1st Sess. 20 (1935), reprinted in II NLRB, *Legislative History of the National Labor Relations Act 1935* ("*1935 Leg. Hist.*") at 2930 (Reprint ed. 1985). See also H.R. Rep. No. 972, 74th Cong., 1st Sess. 20 (1935), reprinted in *1935 Leg. Hist.* at 2976; H.R. Rep. No. 1147, 74th Cong., 1st Sess. 22 (1935), reprinted in *1935 Leg. Hist.* at 3072. As this Court has stated, "[t]he issue as to what unit is appropriate for bargaining is one for which no absolute rule of law is laid down by statute, and none should be by decision." *Packard Motor Car Co.* v. *NLRB*, 330 U.S. at 491.

The court of appeals nonetheless gave three reasons for rejecting the natural interpretation (affirmed by the legislative history) that Section 9(b) requires meaningful, individual bargaining unit determinations on a case-by-case basis. None of these reasons can withstand analysis.

a. First, the court of appeals held that "such interpretations are regularly rejected in decisions involving challenges to agency rules, such as the Social Security Administration's 'grid' method of deciding entitlement to disability benefits. *Heckler* v. *Campbell*, 461 U.S. 458, 467-468 (1983)." App., *infra*, 6a. But the statute involved in *Campbell* did not include any language analogous to the "in each case" requirement of Section 9(b). Moreover, this Court upheld the rule involved in *Campbell* because it involved "an issue that is not unique to each claimant." 461 U.S. at 468. The Court merely held that an "agency may rely on its rulemaking authority to determine issues that *do not require case-by-case consideration.*" *Id.* at 467 (emphasis added). By contrast, bargaining unit determinations *do* involve issues that are unique to each employer. By their nature and by the language of the statute they *do* require case-by-case determination.[5]

A closer look at the *Campbell* decision and the rules at issue in that case actually supports AHA's position that the Board's bargaining unit rules are invalid. The Social Security Act requires the Secretary of Health and Human Services to make a two-part determination. As the Court explained (461 U.S. at 467-468):

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[5] In upholding the regulations in *Campbell*, the Court relied on its previous decisions in *Federal Power Comm'n* v. *Texaco, Inc.*, 377 U.S. 33, 40 (1964), and *United States* v. *Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956). But the Court was careful to emphasize that in those cases—as in *Campbell*—"an individual applicant [was allowed] to show that the rule promulgated should not be applied to him." 461 U.S. at 467 n.11. In this case, however, the Board has foreclosed that possibility by making it clear that the rule applies in *all* cases, except in the rare instance where there are "extraordinary circumstances" warranting a different result.

> [The Secretary] must assess each claimant's individual abilities and then determine whether jobs exist that a person having the claimant's qualifications could perform. The first inquiry involves a determination of historic facts, and the regulations properly require the Secretary to make these findings on the basis of evidence adduced at a hearing. We note that the regulations afford claimants ample opportunity both to present evidence relating to their own abilities and to offer evidence that the guidelines do not apply to them. The second inquiry requires the Secretary to determine an issue that is not unique to each claimant—the types and numbers of jobs that exist in the national economy.

The issues that the Board's rule conclusively determines are like the issues involved in the *first* part of the disability determination: they are matters of historic fact, unique to each hospital. The question of whether a particular bargaining unit is appropriate to a particular hospital (and the question of whether the unit would cause proliferation) involves such issues as the size, location, staffing patterns and operation of the hospital, the degree of functional integration of the workforce, and so on—all unique factual matters that the Board no longer will even consider. NPR II, 53 Fed. Reg. 33932. It is simply nonsensical to regard these issues as analogous to the national availability of jobs issue that the Court held could be determined by rulemaking.

b. The court of appeals also reasoned that the "in each case" language was intended to prevent the Board from siding with either "of the two major labor federations, the AFL and the CIO—the former a federation of craft unions, the latter of plant unions." App., *infra*, 7a. The court stated that "[i]f the Board had ruled that all bargaining units should be craft units or that all should be plant units, it would have altered the balance of power between the federations dramatically. The 'in each case' proviso forbids the Board to do this." *Ibid.*

But the "in each case" language and the entire Act predates the dispute between the AFL and the CIO. The language was added to the Wagner bill in May 1935, and the NLRA was passed the next month. The CIO was formed initially as a committee within the AFL after the AFL convention in October 1935, and did not break away as a separate federation until 1938. As a leading historian of the Act has commented, "[n]one of the draftsmen [of the Wagner Act] foresaw the cleavage in the union movement that appeared later in 1935." I. Bernstein, *The New Deal Collective Bargaining Policy* 96 (1950).[6]

c. The court of appeals' third reason was that it construed the legislative history (including the statement that the appropriateness of a bargaining unit "is obviously [a matter] for determination in each individual case") to mean only "that unit determination is a task meet for the Board rather than for either the Congress or the employees themselves." App., *infra*, 7a-8a. In addition, the court concluded that if Congress had meant the "in each case" language to preclude the kind of rulemaking the Board has undertaken, "it is probable (no stronger statement is possible) that Congress would have made an explicit exception for unit determination" in Section 6 of the Act, which gives the Board rulemaking authority. *Id.* at 8a. Both assertions are incorrect.

To begin with, the statement in the legislative history that the question of whether a bargaining unit is appropriate "is obviously one for determination in each individual case" clearly relates to how bargaining units should be determined, and not to who should make that determination. That statement explains the "in each case"

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[6] See also I. Bernstein, *The Turbulent Years* 400-402, 697-698 (1970); W. Galenson, *The CIO Challenge to the AFL* 3 (1960) ("November 9, 1935 [is] the date usually given as the birthday of the CIO").

language, not the allocation of responsibility for the determination to the Board. This conclusion follows not just from a commonsense reading of Section 9(b) and the passage from the various House Reports, but also from a comparison of those reports with Senate Report No. 573, which was published before the bill was amended to add the "in each case" language. S. Rep. No. 573, 74th Cong., 1st Sess. (1935), reprinted in *1935 Leg. Hist.* 2300. Like the later House Reports, S. Rep. No. 573 discusses the allocation of responsibility and indicates that the Board rather than the employees must determine the appropriateness of bargaining units. *Id.* at 14, *1935 Leg. Hist.* 2313. But it says nothing about the issue being "obviously one for determination in each individual case." That language appears in the legislative history for the very first time in the House Report (No. 969) issued immediately *after* Section 9(b) was amended to add the "in each case" language.

Nor is it "probable" that Congress would have amended Section 6 to make it clear that bargaining unit determinations could not be performed by rulemaking. Congress *did* include an "explicit exception for unit determination"; that exception is the "in each case" language of the subsequent Section 9(b). It simply would have been redundant to repeat the specific exception of Section 9(b) within the more general rule of Section 6. Moreover, it requires a perversion of the canons of statutory construction to argue that the general language of Section 6 overrides the specific language of Section 9(b).[7]

[7] In *Heckler* v. *Campbell* this Court noted that the determination of a disability claimant's abilities required an individual, case-by-case determination. 461 U.S. at 467-468. Yet the Social Security Act gives the Secretary broad rulemaking powers and does not specifically state that those powers do not apply to the Secretary's determination of an individual claimant's abilities. See 42 U.S.C. § 405(a).

3. The court of appeals' interpretation of the "in each case" language cannot be reconciled with the interpretation of that same language by other courts of appeals. Those courts have given full effect to the "in each case" requirement and have required the Board to make individual, case-by-case determinations of whether a bargaining unit was appropriate.

One context in which the courts of appeals have enforced the plain meaning of the "in each case" language has been in rejecting the Board's reliance on prior state agency determinations of bargaining unit appropriateness. In *Memorial Hospital of Roxborough* v. *NLRB*, 545 F.2d 351, 360 (3d Cir. 1976), the Third Circuit held that the Board could not accept a state agency's determination that a bargaining unit was appropriate because to do so would be an abdication of the requirement of individual, case-by-case determination by the NLRB:

> Congress has thus mandated Board determination "in each case" of "the unit appropriate" for collective bargaining. Thus the statute requires the Board to exercise its discretion as to an appropriate unit in each and every case.

See also *Allegheny General Hospital* v. *NLRB*, 608 F.2d 965, 968 (3d Cir. 1979). The Second Circuit reached the same conclusion in *Long Island College Hospital* v. *NLRB*, 566 F.2d 833, 840-841 (2d Cir. 1977), cert. denied, 435 U.S. 996 (1978). Similarly, in *NLRB* v. *Cardox Div. of Chemetron Corp.*, 699 F.2d 148, 155-156 (3d Cir. 1983), the court held that the "in each case" language precluded the Board's reliance on the parties' prior agreement that a unit was appropriate.

The issue has also arisen in another context, in which the courts of appeals have rejected the Board's attempts to apply conclusive (or nearly conclusive) presumptions that certain types of bargaining units are appropriate. For example, in *Big Y Foods, Inc.* v. *NLRB*, 651 F.2d 40 (1st

Cir. 1981), the court of appeals upheld the Board's determination that a separate bargaining unit for the meat department of a grocery chain was appropriate. In discussing the Board's power to decide the appropriate unit, the First Circuit noted that the "in each case" language required individual, case-by-case determinations and precluded reliance on irrebuttable presumptions that certain units are correct (651 F.2d at 45-46; citations omitted):

> The only pertinent limitation [on the Board's powers] is the §9(b) statutory direction to the NLRB to make a decision "in each case." It has been held that that statutory direction invalidates a conclusive presumption because it precludes the NLRB from making a determination based upon the unique circumstances of a particular group of employees. But that statutory direction does not invalidate a rebuttable presumption which has no preclusive effect.

See also *Trustees of the Masonic Hall & Asylum Fund* v. *NLRB*, 699 F.2d 626, 638 (2d Cir. 1983); *NLRB* v. *St. Francis Hospital of Lynwood*, 601 F.2d at 416; *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980). Indeed, in *Newton-Wellesley*, the Board itself acknowledged the effect of the "in each case" language:

> We have concluded that so much of the Board's *St. Francis* decision as may be read to establish an irrebuttable presumption of the appropriateness of registered nurse units in all cases, without regard to particular circumstances, should be disavowed. Such a *per se* approach to unit determinations *is inconsistent with the Board's Section 9(b) responsibility to decide "in each case" whether the requested unit is appropriate.*

Ibid. (emphasis added). See also *St. Francis Hospital*, 265 NLRB at 1028.

The court of appeals' decision to disregard the plain meaning of the "in each case" requirement thus is contrary to the statute and impossible to reconcile with the approach taken by other courts. This Court should grant the petition and make it clear that Section 9(b) of the Act requires individual, case-by-case determinations of bargaining units.

II. The Court Of Appeals' Decision That The Board's Rule Does Not Contravene The Congressional Admonition Is Incorrect And Contrary To The Decisions Of Other Courts Of Appeals

The Board's rule not only is contrary to the express language of Section 9(b), but it is also inconsistent with the Health Care Amendments Act of 1974 and with the admonition contained in both the House and Senate Reports requiring the Board to give "[d]ue consideration * * * to preventing proliferation of bargaining units in the health care industry." App., *infra*, 8a.[8] Other courts of appeals have interpreted that statute to require case-by-case bargaining unit determination in the health care industry and to prohibit the Board from establishing binding presumptions of law that particular units are appropriate. The Seventh Circuit's decision in this case reaches precisely the opposite conclusion. That conflict among the courts of appeals on this important question of statutory construction by itself would require review.

But even without a circuit conflict, this case clearly warrants review. Ironically, the result of the court of appeals' decision is that, despite the congressional admonition that special care be taken in evaluating bargaining units in the health care industry, that industry has now become the *only* one as to which the Board does not provide meaningful, case-by-case determination of bargaining

[8] As this Court has repeatedly recognized, the House and Senate Committee Reports are the most authoritative source for determining congressional intent. *Thornburg* v. *Gingles*, 478 U.S. 30, 43 n.7 (1986); *Garcia* v. *United States*, 469 U.S. 70, 76 (1984); *Zuber* v. *Allen*, 396 U.S. 168, 186 (1969).

unit issues. Instead of taking special care in cases involving the health care industry, the Board proposes to eliminate its traditional, case-by-case approach and to take no particularized care at all in that industry.

The Board has candidly acknowledged that the rule is based on its finding that Congress was wrong when it issued the admonition against proliferation of bargaining units:

> The legislative history showed "proliferation" was opposed by Congress because it was feared that [it] would lead to numerous work stoppages, jurisdictional disputes, and wage whipsawing and leapfrogging. However, as was amply documented in NPR II, multiple units have not been shown to cause an unusual number of work stoppages, nor have they been shown to have caused jurisdictional disputes, wage whipsawing or leapfrogging. * * * [T]he evidence presented to us is that there were virtually none of the disruptive consequences which concerned Congress during the 1974 debates.

Final Rule, 54 Fed. Reg. 16346. Of course, the Board's "finding" ignores the fact that there has *not* been a proliferation of bargaining units in the industry since 1974 because the courts have rejected the Board's approach. Had there been a proliferation of units, the Board then might have been able to examine its impact, but its "finding" of no impact at this point is sheer speculation. In any event, an administrative rule of great importance, that is based not on the agency's desire to carry out the will of Congress but on its finding that Congress was misguided warrants review by this Court.

1. The court of appeals held that the congressional admonition against proliferation of bargaining units "is entitled to our respectful consideration, not only for its intrinsic merits but also for what light it sheds on Congress's intentions in the 1974 amendments." App., *infra*, 12a. Because the 1974 Act applied the provisions of the National Labor Relations Act (including Section 9(b)) to

most private hospitals for the first time, the court found that the admonition should be regarded "as equivalent to pre-enactment legislative history, rather than as a gratuitous comment unrelated to legislative action." *Ibid.* Nevertheless, the court below declined to follow the lead of the Ninth and Tenth Circuits and instead held that the statute as interpreted in light of the admonition did *not* preclude the Board from adopting a rule that specific bargaining units would be presumed as a matter of law to be appropriate in each and every acute-care hospital in the country.

Although the Board's decision to engage in rulemaking was historic, the rule itself provides nothing new. The rule establishes eight bargaining units that are quite similar to the units the Board initially designated as appropriate in the years following enactment of the Health Care Amendments Act. *St. Francis Hospital*, 265 NLRB 1025, 1029 (1982); *Allegheny General Hospital*, 239 NLRB 872, 888 (1978) (Member Penello, dissenting). See C. Morris, *The Developing Labor Law* 438 (1983).[9] And from early on, the Board asserted—as it does in the rule—that at least some of those units (particularly registered nurses) were to be considered appropriate "*per se*" and that evidence to the contrary would not be considered. *Mercy Hospitals*, 217 NLRB at 767; *Methodist Hospital of Sacramento, Inc.*, 223 NLRB 1509 (1976). It was that very approach—the same approach now embodied in the Board's rule—that was repeatedly rejected by the courts of appeals.

[9] See also *Ohio Valley Hospital Ass'n*, 230 NLRB 604 (1977) (physicians); *Mercy Hospitals*, 217 NLRB at 770-771 (separate units of registered nurses, service and maintenance employees, and office clericals); *Newington Children's Hospital*, 217 NLRB 793 (1975) (service and maintenance unit); *Barnert Memorial Hospital Center*, 217 NLRB 775 (1975) (technical employees); *Peninsula Hospital Center*, 219 NLRB 139 (1975) (guards).

In *NLRB* v. *St. Francis Hospital of Lynwood*, the Board applied the *Mercy Hospital* rule that a unit of registered nurses would be regarded as *per se* appropriate for all hospitals. The Board refused to consider evidence proffered by the hospital that the bargaining unit should include all professionals, stating that under its announced rule, the nurses unit was conclusively presumed to be appropriate. 601 F.2d at 407-408. The Ninth Circuit denied enforcement, holding that the Board's rule was contrary to "the congressional directive that the Board give 'due consideration' to preventing undue proliferation of bargaining units in the health care industry and Congress's expressed approval of the trend toward broader units in this area." *Id.* at 414. The court of appeals agreed that a unit of registered nurses ordinarily might be valid, but held that a rule that created a legal presumption that such a unit always was appropriate and that restricted the ability of the employer to offer evidence that the unit was not appropriate in a particular situation was contrary to the statute and to the admonition against proliferation. *Id.* at 416.

The Tenth Circuit reached the same conclusion in *Presbyterian/St. Lukes Medical Center* v. *NLRB*, 653 F.2d at 457. See also *Beth Israel Hospital & Geriatric Center* v. *NLRB*, 677 F.2d 1343, 1345 (10th Cir. 1981), modified in other respects, 688 F.2d 697 (10th Cir.). And the Second Circuit, in upholding a unit of service and maintenance workers, indicated that "the Board would abuse its discretion were it to make a unit determination in the health care field solely on the basis of a presumption of appropriateness. * * * [I]n the health care field, the Board must specify how its unit determination implements or reflects the congressional admonition. * * * The Board is committed to evaluating each unit petition on the facts." *Trustees of the Masonic Hall & Asylum Fund* v. *NLRB*, 699 F.2d at 638.

The Board rule involved in this case is identical in all relevant respects to the rule rejected by the Ninth and Tenth Circuits. The rule creates a binding presumption of law that the eight units are appropriate in every hospital and prohibits employers from introducing evidence to show that a particular unit is not appropriate. NPR II, 53 Fed. Reg. 33932-33933. If a union acting under the Board's new rule petitioned to represent the registered nurses at Mercy Hospital or Presbyterian/St. Lukes Medical Center, the Board again would hold that the unit was appropriate *per se* and again would preclude the hospitals from offering evidence to the contrary. In light of their prior decisions holding that the Board must give employers a meaningful opportunity to present evidence that the unit is inappropriate to that particular hospital, there is absolutely no reason to believe that the Ninth or Tenth Circuits would now uphold the Board's application of its new rule.

In opposing the AHA's motion for a stay of the mandate, the Board argued that there was no conflict with the Seventh Circuit's decision because the Ninth and Tenth Circuits had "essentially held" that the Board had not provided "an adequate empirical basis" for its rule. Opposition Of The National Labor Relations Board To Plaintiff-Appellee's Motion For Stay Of Mandate, at 4 n.2. There is nothing in either of those courts' opinions to support that contention. To the contrary, in *St. Francis Hospital of Lynwood*, the Ninth Circuit specifically noted that even if the Board had previously established presumptions based on adequate evidence, it would still be required to give the hospital in the particular case where the presumptions were applied "the opportunity to effectively present evidence to rebut the presumptions." 601 F.2d at 416. And in *Presbyterian/St. Lukes Medical Center*, the Tenth Circuit went even further,

holding that "any use of a presumption which casts upon the Medical Center the burden of producing evidence of the inappropriateness of the unit violates Congress' directive of nonproliferation in the health care industry. * * * [T]he Board must specify 'the manner in which its unit determination *in this case* implement[s] or reflect[s] that admonition.' " 653 F.2d at 457 (emphasis added). Thus, the conflict among the circuits is clear and requires this Court's resolution.[10]

III. The Board's Rule Is Arbitrary And Capricious And Not Supported By Substantial Evidence Insofar As It Ignores Critical Differences Among Hospitals

Even if the language and legislative history of the NLRA permitted the Board to establish bargaining units based on conclusive presumptions, the Board's rule would still be arbitrary, capricious, and not supported by substantial evidence insofar as it ignores critical differences among hospitals, including differences in size, location, and operations. Although the district court found it unnecessary to reach this issue, the court of appeals—without any detailed examination of the evidence in the record—held that the rule was not arbitrary.

[10] The courts of appeals are also in conflict over the more general issue of the effect to be given to the congressional admonition. Most of them have held that the admonition is binding and prohibits the Board from applying its traditional unit determination criteria in cases involving the health care industry. See, *e.g.*, *Trustees of the Masonic Hall & Asylum Fund* v. *NLRB*, 699 F.2d at 632 (2d Cir.); *NLRB* v. *HMO Int'l/California Medical Group Health Plan, Inc.*, 678 F.2d at 808 (9th Cir.); *NLRB* v. *St. Francis Hospital of Lynwood*, 601 F.2d at 412 (9th Cir.); *St. Anthony's Hospital Systems, Inc.* v. *NLRB*, 884 F.2d 518, 519-520 & n.3 (10th Cir. 1989).

The District of Columbia Circuit, on the other hand, has held that the congressional admonition has virtually no binding effect on the Board. *International Brotherhood of Electrical Workers* v. *NLRB*, 814 F.2d at 712. The Seventh Circuit in this case struck an intermediate position, holding that the admonition is entitled to some "respectful consideration" but that it is not binding "as if it were a statute." App., *infra*, 12a.

The court of appeals characterized AHA's argument that the rule improperly lumped together hospitals of greatly differing size, missions and locations as "an important criticism." App., *infra*, 14a. Nevertheless, it refused to strike down the rule on that ground because the hospital industry had failed to propose alternatives or to seek modification of the Board's rule (*ibid.*):

> This is an important criticism but it would impress us more if the industry had proposed an alternative that recognized the diversity of the industry but preserved the virtues of a rule. * * * Another way in which the industry failed to respond constructively to the Board's desire to bring unit determination in the acute-care hospital industry under a rule was by failing to press for an increase in the six-employee minimum [for employees in a unit].

The relevant issue, however, is *not* whether petitioner offered and supported a reasonable alternative, but whether the Board's rule was arbitrary, capricious, or not supported by substantial evidence. 5 U.S.C. § 706(2)(A), (E). The court of appeals failed seriously to examine that issue.

Had the court of appeals looked more closely at the record, it would have found that the evidence supports only one conclusion: that the differences among hospitals are so great as to make any blanket rule arbitrary. The Board claimed at several points that its experience in handling hundreds of hospital bargaining unit cases over 13 years demonstrated that all such facilities were "remarkably uniform" and "virtually identical." NPR I, 52 Fed. Reg. 25143-25145; NPR II, 53 Fed. Reg. 33932-33933. But the Board itself acknowledged just five years before that "[the] diverse nature of today's health care industry

* * * precludes any generalization as to the appropriateness of any particular bargaining unit." *St. Francis Hospital*, 271 NLRB 948, 953 n.39 (1984). A close examination of the evidence in the record would confirm that the Board's earlier assessment was correct. In health care, as in other industries, "wide variations [and] complexities of modern industrial organization [preclude] the use of inflexible rules as the test of an appropriate unit." *NLRB* v. *Hearst Publications, Inc.*, 322 U.S. at 134.

Absent evidence that the health care industry had changed radically over the past five years—and there was no such evidence in the record—the Board's new and drastically altered "finding" warranted more thorough analysis than that provided by either the Board or the court below. *Motor Vehicle Manufacturers Ass'n* v. *State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29, 42 (1983).

IV. The Court Of Appeals' Decision Raises Issues Of Great National Consequence That Need To Be Resolved By This Court

The importance of this case to the delivery of health care in the country—and to millions of hospital employees—cannot be overestimated and has been acknowledged by all of the parties. The NLRB stated in the court of appeals that AHA's challenge to the validity of the rule "raises an issue of unusual public importance, for the Rule establishes bargaining units for a major segment of the health care industry * * *." Motion For Priority Consideration In Setting Oral Argument at 3. The AFL-CIO also believes that it is essential to obtain "a *speedy* resolution of the industry's challenge to the validity of the Rule" (AFL-CIO Memorandum In Support Of Motion To Intervene at 6) because "only a decision by the U.S. Supreme Court will put an end to the protracted litigation in this area." "Unions Want NLRB to Jump the Gun on Bargaining Units," *Modern Healthcare*, Nov. 25, 1988, at 33. Similarly, when AHA indicated that it planned to seek review in this Court, a spokesperson for the American Nurses Association remarked that "[a]ll the parties have expected Supreme Court review of the rulemaking process." Bureau of National Affairs, *Daily Labor Report* A-14 (April 26, 1990).

In AHA's view—based on the experience of its 5,500 member hospitals—the Board's designation of eight bargaining units in each and every acute-care hospital licenses the very proliferation of units that Congress sought to preclude. The rule would increase the number and severity of strikes and the use of tactics such as "whipsawing" and "leapfrogging" by hospital unions. It thus not only would disrupt the delivery of health care, but also would significantly increase its cost at a time when escalating health care expenses are a pressing national problem. We do not expect the Board or the union respondents to agree that the rule would have such a disastrous impact,[11] but their expenditure of enormous resources on the rulemaking process testifies to their perception of the importance of the rule.

As lawyers in the health care field already have promised, the alternative to review in this Court would be case-by-case, hospital-by-hospital challenges to bargaining unit determinations:

> [H]ospitals are entitled to challenge the rules in 47 other states. "Until the Supreme Court ultimately passes on the validity of the unit determination rules . . . we will proceed in our clients' representation cases in precisely the same way as we have done so in the past."

[11] Indeed, the Board's rule is based on its express finding that Congress was misguided in its concerns about unit proliferation. Final Rule, 54 Fed. Reg. 16346.

Statement of hospital attorney Roger King, reported in *Modern Healthcare*, April 23, 1990, at 3.

Review by this Court is essential not merely to prevent the disruption of health care and the increase in hospital costs that AHA believes will be caused by implementation of the Board's rule, but also to prevent the disruption and costs that surely will be caused by allowing the validity of the rule to become the subject of hospital-by-hospital wrangling and litigation around the country. It is time to get the matter finally resolved.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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July 1990

APPENDIX

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

Nos. 89-2604, 89-2605, 89-2622

AMERICAN HOSPITAL ASSOCIATION,
Plaintiff-Appellee,
v.

NATIONAL LABOR RELATIONS BOARD, JAMES M. STEPHENS, MARY M. CRACRAFT, JOHN E. HIGGINS, JR., DENNIS M. DEVANEY, AND JOHN C. TRUESDALE,
Defendants,
and

AMERICAN NURSES ASSOCIATION, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS, AND BUILDING AND CONSTRUCTION TRADES DEPARTMENT, AFL-CIO,
Intervening Defendants-Appellants.

ARGUED JANUARY 10, 1990—DECIDED APRIL 11, 1990

Before POSNER, RIPPLE, and KANNE, *Circuit Judges.*

POSNER, *Circuit Judge.* The National Labor Relations Board, joined by intervening unions, appeals from an order by the district court enjoining the first significant substantive exertion of the rulemaking powers conferred on the Board, almost half a century ago, by section 6 of the National Labor Relations Act, 29 U.S.C. § 156. By "substantive," we mean other than jurisdictional, procedural, or remedial.

Section 9(b) of the Act, 29 U.S.C. § 159(b), directs the Board to determine in each case the appropriate unit for collective bargaining. The rule that the district court enjoined provides that, save in extraordinary circumstances, the Board will recognize the following, and only the following, eight bargaining units for employees of acute-care hospitals: physicians, registered nurses, other professional employees, medical technicians, skilled maintenance workers, clerical workers, guards, and other nonprofessional employees. *Collective-Bargaining Units in the Health Care Industry*, 52 Fed. Reg. 25142 (1987) (notice of rulemaking), 53 Fed. Reg. 33900 (1988) (further notice), 54 Fed. Reg. 16336 (1989) (final rule), enjoined, 718 F.Supp. 704 (N.D. Ill. 1989). No unit, however, will be certified that has fewer than six employees. The rule is limited to acute-care hospitals, but does not differentiate among them by size or location except insofar as the six-employee minimum may prevent the formation of all eight units in the smallest hospitals. Section 9(b) itself entitles guards to form their own separate unit, 29 U.S.C. § 159(b)(1), so we may assume that the six-employee minimum does not apply to guards (the Board's rule is silent on the question). But a hospital would still have to have a minimum of 43 employees for all eight bargaining units to be recognized in it—one guard plus six employees in each of the other seven units. The statute also entitles professional employees to bargain separately from nonprofessional employees, 29 U.S.C. § 159(b)(1), but there will always be more than six professional employees in a hospital or other facility covered by the rule.

The hospital industry objects to any rule that requires the recognition of more than the statutory minimum of three units—professional employees, guards, and other nonprofessional employees. Which is to say that it objects to any rule at all, since no rule is necessary to confer rights already conferred by the statute.

Labor and management are perennially and systematically at odds over the appropriate number of bargaining units. *NLRB* v. *Res-Care, Inc.*, 705 F.2d 1461, 1468-71 (7th Cir. 1983); *Continental Web Press, Inc.* v. *NLRB*, 742 F.2d 1087, 1090 (7th Cir. 1984); Note, *The National Labor Relations Board's Proposed Rules on Health Care Bargaining Units*, 76 Va. L. Rev. 115, 117-18, 121-122 (1990). From organized labor's standpoint, generally the more units there are the better. This is because the smaller and more homogeneous a bargaining unit is, the easier it will be for the members to agree on a mutually advantageous course of collective action, and therefore the more attractive a union will be, unionization being the vehicle for collective action by employees. By the same token, the larger and more heterogeneous the unit is, the harder it will be for the members to agree on a common course of action. The diversity of, often amounting to conflict between, the interests of the members of a large and heterogeneous unit will make collective action difficult, so it will be hard for a union to gain majority support in such a unit or, having gained it, to use it to bargain effectively (for example, by making a credible threat to strike). This is the union's perspective; the employer's perspective is different. The more units there are, the more costly it will be for the employer to negotiate collective bargaining contracts. And work stoppages will be likelier, because there will be more separate decision-making centers each of which can call a strike, and because majority support for a strike call is more likely the more homogeneous a unit is and hence the likelier all members are to benefit if the union wins.

In making unit determinations the Board is thus required to strike a balance among the competing interests of unions, employees (whose interests are not always identical with those of unions), employers, and the broader

public. The statute, though otherwise nondirective, can be read to suggest that the tilt should be in favor of unions, and hence toward relatively many rather than relatively few units. *NLRB* v. *Res-Care, Inc., supra*, 705 F.2d at 1469; but see 29 U.S.C. § 159(c)(5); *Continental Web Press, Inc.* v. *NLRB, supra*, 742 F.2d at 1090-91. The statute states: "The Board shall decide in each case whether, *in order to assure to employees the fullest freedom in exercising the rights guaranteed by* [the National Labor Relations Act], the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof." 29 U.S.C. § 159(b) (emphasis added). It is true that among the rights that the Act explicitly confers on workers is the right not to organize. 29 U.S.C. § 157. But even with the Taft-Hartley amendments this is not the *principal* right of workers under the National Labor Relations Act. The principal purpose of the Act was and is to protect workers who want to organize for collective bargaining.

In any event, the precise balance among the competing interests is certainly not spelled out in the statute; it is for the Board to decide. *NLRB* v. *Res-Care, Inc., supra*, 705 F.2d at 1469; *Continental Web Press, Inc.* v. *NLRB, supra*, 742 F.2d at 1090. The decision is particularly difficult and delicate in the health care industry because the work force of a hospital (or nursing home or rehabilitation center) tends to be at once small and heterogeneous. It may include physicians, registered nurses, psychologists, licensed practical nurses, nurses' aides, lab technicians, orderlies, physical therapists, dieticians, cooks, guards, clerical workers, maintenance workers, guards, and others—but often only a few of each. If the desirability (from the union standpoint) of homogeneous units is stressed, even a hospital of average size might have ten or twenty or even more units, each with a bare handful of workers.

The cost of the institution's labor relations and the probability of work stoppages would soar. Wages might soar too (depending of course upon competition among hospitals), since proliferation of units fosters unionization and a principal objective of unions is to raise their members' wages. But this is far from certain; workers do not receive wages when they are on strike, and strike-prone workers are worth less to employers.

Work stoppages, heavy bargaining costs, soaring wages, labor unrest—all these are matters of concern in a period of high and rising costs of health care, and indeed, as we shall see, commanded congressional attention even before the tide came in. The sorting out and weighing of these matters are judgmental functions committed to the Board.

The Board's rulemaking power is explicit and broad. Section 6 provides: "The Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by the Administrative Procedure Act, such rules and regulations as may be necessary to carry out the provisions of [the National Labor Relations Act]." (The reference to the APA was added in 1947; the rest of the provision dates back to the original Act.) The industry does not argue that the power is confined to nonsubstantive matters or has atrophied from disuse, and there is broad although not unanimous agreement in the legal community, which we and other courts have remarked approvingly, that the exercise of the Board's dormant substantive rulemaking power is long overdue. *NLRB* v. *Wyman-Gordon Co.*, 394 U.S. 759, 765 n.3 (1969); *id.* at 769-80 (concurring opinion); *NLRB* v. *Res-Care, Inc., supra*, 705 F.2d at 1466; *Continental Web Press, Inc.* v. *NLRB, supra*, 742 F.2d at 1093-94; *NLRB* v. *Majestic Weaving Co.*, 355 F.2d 854, 859-61 (2d Cir. 1966) (Friendly, J.); *International Union of Operating Engineers* v. *NLRB*, 353 F.2d 852, 856 n.16 (D.C. Cir. 1965); Peck, *A Critique of*

the National Labor Relations Board's Performance in Policy Formulation, 117 U. Pa. L. Rev. 254 (1968); Morris, *The NLRB in the Dog House*, 24 San Diego L. Rev. 9, 27-42 (1987); Shapiro, *Why Do Voters Vote?*, 86 Yale L.J. 1532, 1543-45 (1977); cf. *Mosey Mfg. Co.* v. *NLRB*, 701 F.2d 610, 612 (7th Cir. 1983) (en banc); but see Williams, *The NLRB and Administrative Rulemaking*, 16 Inst. Labor L. 209 (1970). We are speaking of explicit rulemaking; the Board also of course has long made rules in common law fashion, case by case, and its power to make rules this way is no longer open to doubt. *NLRB* v. *Bell Aerospace Co.*, 416 U.S. 267, 290-95 (1974). Its rulemaking power is not less when it proceeds, under the explicit authority of section 6, in accordance with the procedures that the Administrative Procedure Act prescribes for rulemaking.

There is, however, a question whether the Board is authorized to make a rule recognizing eight separate bargaining units in the acute-care hospital industry. The district judge thought not, and the industry defends his conclusion on three separate grounds. The first is based on the text of section 9(b): "The Board shall decide [the appropriate unit] *in each case*" (emphasis added), implying the industry argues, that the Board must determine the appropriate unit on a case by case basis, except for the irreducible minimum of three units authorized by the statute itself. We do not interpret the statute so, and note that such interpretations are regularly rejected in decisions involving challenges to agency rules, such as the Social Security Administration's "grid" method of deciding entitlement to disability benefits. *Heckler* v. *Campbell*, 461 U.S. 458, 467-68 (1983). The reference in section 9(b) to employer, craft, and plant units suggests that the term "in each case" was included to prevent the Board from bringing about a revolution in unit determinations by prescribing employer units, or craft units, or plant units for all employers under the Board's jurisdiction. At the time the Wagner Act was passed, there was an enormous diversity of bargaining units, in major part reflecting the different characters of the two major labor federations, the AFL and the CIO—the former a federation of craft unions, the latter of plant unions. If the Board had ruled that all bargaining units should be craft units or that all should be plant units, it would have altered the balance of power between the federations dramatically. The "in each case" proviso forbids the Board to do this. But it is consistent with the background and semantics of the proviso that a "case" can be an industry or (as here) a subset or submarket of an industry; it need not be a particular dispute between a particular employer and a particular union at a particular plant or establishment.

Another possibility is that "in each case" simply expresses the truism that, whether or not the Board proceeds by formal rulemaking, it still must determine the bargaining units in each case in which there is a dispute over how to classify particular workers. In other words, a rule, like a statute, is applied case by case. Still another possibility is that "case" means "proceeding" in a sense broad enough to cover a rulemaking proceeding as well as an adjudicative one.

The legislative history of "in each case" is scanty, but the House Reports do say that "section 9(b) provides that the Board shall determine . . . [the appropriate unit]. This matter is obviously one for determination in each individual case, and the only possible workable arrangement is to authorize the impartial governmental agency, the Board, to make that determination." H.R. Rep. No. 972, 74th Cong., 1st Sess. 20 (1935); H.R. Rep. No. 1147, 74th Cong., 1st Sess. 22 (1935). In context, all this appears to mean is that unit determination is a task meet for the

Board rather than for either the Congress or the employees themselves. And since three sections earlier in the National Labor Relations Act, in a provision (section 6) enacted at the same time as section 9(b), Congress had granted the Board explicit rulemaking power, it is probable (no stronger statement is possible) that Congress would have made an explicit exception for unit determination if it had wanted to place that determination outside the scope of the Board's rulemaking power.

The industry makes no argument that unit determination is inherently less suitable for rulemaking than any of the other dimensions of labor relations regulated by the Board. Nor is the procedure the Board has followed the focus of the industry's challenge; the industry would have objected just as vigorously if the Board had announced the rule in an adjudicative proceeding, as it has announced virtually all of its substantive rules until this one. The broad discretion that the statute grants the Board in the matter of unit determination is an invitation to the Board to bring order out of chaos through rules, and rulemaking is often and perhaps here a superior method of making rules than adjudication is. Since there is no reason why Congress might have wanted to carve out unit determinations from the grant of rulemaking power in section 6 and no indication beyond the ambiguous semantics of the word "case" that it did want to do this, we conclude that unit determinations is not excepted from the Board's power under that section.

The second ground on which the industry urges us to uphold the injunction is that the Board's rule is inconsistent with the following statement in the congressional committee reports accompanying the Health Care Amendments Act of 1974:

> Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).[1]

S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). (The footnote states: "By our reference to *Extendicare* we do not necessarily approve all of the holdings of that decision.") The background and application of this passage are discussed exhaustively in the majority and concurring opinions in *International Brotherhood of Electrical Workers* v. *NLRB*, 814 F.2d 697 (D.C. Cir. 1987), allowing us to be brief.

Before the 1974 amendments, nonproprietary (i.e., nonprofit) hospitals—which dominated the hospital industry then even more than they do now—were not subject to the Board's jurisdiction, and, possibly as a result, there was little union activity in the hospital sector. Naturally the industry opposed the extension of the Board's jurisdiction to the nonproprietaries, but not having the muscle to defeat the extension focused its efforts on securing provisions to require ten-day advance notice of strikes and to limit the number of bargaining units (one proposal was to limit the number to four). Union interests opposed both provisions. The result of the collision of interest groups was a compromise whereby advance notice of strikes was required, 29 U.S.C. § 158(g); *East Chicago Rehabilitation Center, Inc.* v. *NLRB*, 710 F.2d 397, 401-04 (7th Cir. 1983), but no change was made in the unit-determination statute. However, the industry did succeed in persuading the members of the House and Senate committees to include in the committee reports the admonition concerning unit proliferation that we have quoted.

Ordinarily a committee report that is not explaining new or altered statutory language has little significance in the interpretation of a statute. *Public Employees Retirement System* v. *Betts*, 109 S. Ct. 2854, 2861 (1989). Suppose a congressional committee issued a report expressing disagreement with a decision by the Supreme Court interpreting a provision of the Sherman Act unchanged since 1890. The report might be a persuasive document by virtue of the cogency of its reasoning but it would have no *legislative* significance. Congress legislates by passing bills and sending them to the President for his signature. It does not legislate by issuing committee reports. *Prussner* v. *United States*, 896 F.2d 218, 228 (7th Cir. 1990) (en banc); *In re Sinclair*, 870 F.2d 1340 (7th Cir. 1989). Post-enactment legislative history (an oxymoron—the history of an event lies in its past, not its future) is sometimes a sneaky device for trying to influence the interpretation of a statute, in derogation of the deal struck in the statute itself among the various interests represented in the legislature. *Covalt* v. *Carey Canada Inc.*, 860 F.2d 1434, 1438-1439 (7th Cir. 1988); *In re Tarnow*, 749 F.2d 464, 467 (7th Cir. 1984). Courts must be careful not to fall for such tricks and thereby upset a legislative compromise.

If, however, Congress does enact a statute, the committee reports explaining it may have considerable significance in guiding interpretation. We say this fully aware that a growing number of judges disagree. They regard committee reports (and *a fortiori* the rest of legislative history—hearings and rejected bills and floor debate) as illegitimate efforts to influence judicial interpretation. We reviewed this skeptical literature in *In re Sinclair*, *supra*, 870 F.2d at 1343-44, but we did not endorse it, noting that "clarity depends on context, which legislative history may illuminate." *Id.* at 1342. The expressed purposes of the drafters of statutory language can assist in interpretation, especially of ambiguous language. Sometimes a committee report is designed to give a statute a spin not intended by a majority of the Congress that enacted it or by the President that signed it, *Green* v. *Bock Laundry Machine Co.*, 109 S. Ct. 1981, 1994 (1989) (concurring opinion); *Hirschey* v. *FERC*, 777 F.2d 1, 7 n.1 (D.C. Cir. 1985) (concurring opinion), but the extent of this abuse remains unclear. For divergent views on its prevalence, see Judges and Legislators: Toward Institutional Comity 170-75 (Katzmann ed. 1988). Judges should be alert to the possibility of abuse, but should also be careful not to throw out the baby with the bathwater.

The admonition in the 1974 committee reports is certainly not a statute, *Mary Thompson Hospital, Inc.* v. *NLRB*, 621 F.2d 858, 864 (7th Cir. 1980) (dissenting opinion), and courts that have treated it as such have in our view erred. (The dissent thought the majority had done that in *Mary Thompson*, but we do not read the majority opinion so—its concern was with what seemed the Board's willful refusal even to consider the admonition or the case law in determining bargaining units in the health-care industry.) The admonition lies between the polar cases of a committee report that does not accompany legislative action and a committee report that explains a newly enacted or amended statute, but is we think closer to the latter. It accompanied the enactment of substantial amendments. The particular statutory provision to which the admonition was addressed was not amended, but the effect of the amendments was to apply that provision for the first time to the nonproprietary hospital industry. Section 9(b) directs the Board to determine the "appropriate" unit, and what is appropriate may differ from one industry to another—may therefore "mean" something different in one industry from what it means in another. So in changing the domain of application of section 9(b), the 1974

amendments may have changed its meaning without changing its words. The admonition can therefore be regarded as a commentary on the meaning of the 1974 amendments and hence as equivalent to pre-enactment legislative history, rather than as a gratuitous comment unrelated to legislative action—the case in *Pierce* v. *Underwood*, 108 S. Ct. 2541, 2551 (1988), and *Center for Auto Safety* v. *Peck*, 751 F.2d 1336, 1351 (D.C. Cir. 1985).

And yet the fact that the hospital industry would have dearly loved to amend the unit-determination provision yet failed to do so must give us pause in treating the "admonition" as if it were a statute, which anyway it plainly is not. To treat it as one would give the hospital industry something it tried and failed to win from Congress. Moreover the admonition does not *read* like a statute. It is cautionary rather than directive. It expresses a concern felt by many members of Congress, including those who were responsible for shepherding the bill through both houses, and such an expression is entitled to our respectful consideration, not only for its intrinsic merits but also for what light it sheds on Congress's intentions in the 1974 amendments. But it is not an amendment to section 9(b), decreeing that in the health-care industry no more than three separate bargaining units shall be authorized.

It could not properly be so interpreted even if it were a statute, rather than a statement in committee reports. The background against which the committees expressed their concern with unit proliferation was one to which the word "proliferation" far more compellingly applied than it does to the eight units (three statutory) prescribed in the Board's rule. There are many more than eight groups of hospital employees who consider themselves to have common interests distinct from those of the other groups. Congress was told that New York State's counterpart to

the NLRB had recognized more than 21 separate bargaining units in the hospitals of New York. Hearings on H.R. 11357 Before the Subcomm. on Labor of the S. Comm. on Labor and Public Welfare, 92d Cong., 2d Sess. 300-01 (1972). *That* is proliferation; that is the sort of unit metastasis that "due consideration" could be expected to persuade the Board to disallow. The cases cited in the admonition were ones in which the Board had rejected minuscule or arbitrary units of specialized nonprofessional employees. The rejected unit in *Four Seasons Nursing Center*, 85 L.R.R.M. 1093 (1974), had only two members. In *Woodland Park Hospital*, 84 L.R.R.M. 1075 (1973), the rejected unit consisted of X-ray technicians, and the Board found that they were no different in material respects from the other technicians employed by the hospital. And in *Extendicare of West Virginia, Inc.*, 83 L.R.R.M. 1242 (1973), the Board rejected the employer's request for a single bargaining unit, instead recognizing separate units of technical employees, service and maintenance employees, and licensed practical nurses. Even if we indulge the heroic assumption that members of Congress had actually read the cases, but see *Friedrich* v. *City of Chicago*, 888 F.2d 511, 517 (7th Cir. 1989), neither the cases cited in the admonition nor the admonition itself reads on the issue of the propriety of eight units. So it is merely a detail that the footnote to the admonition makes the committee's view of *Extendicare* completely inscrutable.

At argument we pressed counsel for examples of cases in which, either before or after 1974, the Board or a court had deemed the failure to combine workers from two or more of the eight separate units recognized by the Board's rule—say, clerical workers with maintenance workers, or licensed practical nurses with orderlies, or psychologists with physical therapists—a manifestation of proliferation. No examples were forthcoming. The term has always had

reference to finer divisions of the health-care work force than attempted in the rule under challenge.

The last ground on which the industry defends the injunction is that the Board's rule is arbitrary, because it lumps together hospitals of different sizes and missions in different locations. *All* acute-care hospitals are covered, from the smallest rural hospital having at least six employees in one or more of the prescribed units to the largest metropolitan hospital. This is an important criticism but it would impress us more if the industry had proposed an alternative that recognized the diversity of the industry but preserved the virtues of a rule; the only alternative it proposed is a rule that would state a rebuttable presumption that the three statutorily separate units are appropriate. Such a rule is no rule. It simply assigns to the unions the burden of persuading the Board to allow more units than the statutory minimum. There is no basis for placing this burden on the unions, especially given the statutory declaration that unit determination is to be guided by the desirability of maximizing the bargaining freedom of the employees.

Another way in which the industry failed to respond constructively to the Board's desire to bring unit determination in the acute-care hospital industry under a rule was by failing to press for an increase in the six-employee minimum. If the minimum were, say, fifteen, the effect would be to confine the rule to the larger hospitals. But the industry did not ask the Board to fix a higher minimum. Quite the contrary, it joined the unions in opposing a proposed distinction between hospitals having more than one hundred beds and hospitals having fewer. 53 Fed. Reg. at 33927.

The lumping together of all acute-care hospitals into one category for purposes of prescribing proper bargaining

units does of course overlook a great deal of relevant diversity. What the hospital industry refuses to acknowledge is that this is the very nature of rules. A rule makes one or a few of a mass of particulars legally decisive, ignoring the rest. The result is a gain in certainty, predictability, celerity, and economy, and a loss in individualized justice. Often the tradeoff is worthwhile; at least the prevalence of rules in our legal system so suggests. The hospital industry is acutely conscious of the costs of rules, but disregards the benefits. Because of the absence of statutory guidance and the complexity and uncertainty of the balance that the Board is required to strike in order to determine an appropriate unit, unit determination when made on a case by case basis has all the disadvantages of discretionary justice.

For its first forty-four years the Board tried to channel its discretion over unit determination in common law fashion, proposing and modifying standards case by case. That was the approach it took when the nonprofit health care sector was brought under its aegis in 1974. The approach is widely regarded as a failure, not least by the courts of appeals, including this court; certainly the Board was entitled to regard it as such. "Thirteen years and many hundreds of cases later, the Board finds that despite its numerous, well-intentioned efforts to carry out congressional intent through formulation of a general conceptual test, it is now no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974." 52 Fed. Reg. at 25143. Against this dismal background it was not unreasonable for the Board to experiment with substituting a tight rule for a loose standard. Necessarily the result would be a suppression of relevant detail. Although the rule is not as simple as it could be—it does not cover the entire health-care industry but only acute-care hospitals, and it leaves an open-ended

exception for cases in which a party can demonstrate exceptional circumstances—it could of course be less simple. It could differentiate among acute-care hospitals by size, location, or mission (e.g., primary versus secondary versus tertiary care hospitals). The Board considered these possibilities but decided against them. It gave plausible reasons for its choice.

The decision how complex to make a rule—that is, how many exceptions to recognize—is judgmental, like the decision whether to make rules by formal rulemaking or by the common law method of case-by-case adjudication. *NLRB* v. *Bell Aerospace Co.*, *supra*, 416 U.S. at 290-95. The decision how much discretion to eliminate from the decisional process is itself a discretionary judgment, entitled to broad judicial deference. *Heckler* v. *Campbell*, *supra*, 461 U.S. at 467-68; *Fook Hong Mak* v. *INS*, 435 F.2d 728, 730 (2d Cir. 1970) (Friendly, J.); *Midtec Paper Corp.* v. *United States*, 857 F.2d 1487, 1501 (D.C. Cir. 1988). It is not for us to fine-tune the regulatory process by telling the Labor Board that its rule should make slightly more distinctions than it does, or slightly fewer. The Board did a responsible job of weighing the conflicting arguments, and we therefore uphold its rule without pretending that we consider it Utopia. And there was no statutory obstacle to the Board's bringing the unit-determination process in the hospital industry under the aegis of a rule.

The injunction is vacated with directions to enter judgment for the Board.

REVERSED

No. 89 C 3279

IN THE
UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS

July 25, 1989

AMERICAN HOSPITAL ASSOCIATION,

Plaintiff,

v.

NATIONAL LABOR RELATIONS BOARD, James M. Stephens, Mary M. Cracraft, John E. Higgins, Jr., Dennis M. Devaney, and John C. Truesdale,

Defendants,

and

American Federation of Labor and Congress of Industrial Organizations, the Building and Construction Trades Department, and American Nurses' Association,
Permissive Intervenors Pursuant to Fed.R.Civ.P. 24(b)

MEMORANDUM OPINION AND ORDER

ZAGEL, *District Judge.*

The American Hospital Association (the "AHA") seeks to permanently enjoin the National Labor Relations Board (the "NLRB" or the "Board") from enforcing a newly promulgated rule, 29 C.F.R. Part 103, pertaining to bargaining units in the health care industry (the "Rule").[1] The Rule was promulgated pursuant to the Board's rule-

[1] On April 21, 1989, AHA filed a complaint in this court seeking an injunction enjoining enforcement of the Board's Rule and a judgment that the Rule is invalid. On May 22, 1989, this court issued a preliminary injunction and ordered an expedited briefing schedule.

making authority under section 6 of the National Labor Relations Act (the "NLRA" or the "Act"), 29 U.S.C. sec. 156 (1988), and the procedures set forth in section 553 of the Administrative Procedures Act (the "APA"), 5 U.S.C. sec. 553 (1988). If given effect, the Rule will establish eight units for the purposes of collective bargaining in acute care hospitals. Prior to this Rule the Board's policy was to determine the appropriateness of bargaining units in individual cases. The AHA asks us to declare this Rule invalid on three alternative grounds: 1) the Rule contravenes section 9(b) of the Act, 29 U.S.C. sec. 159(b) (1988), which provides that bargaining unit determinations must be made "in each case", 2) the Rule contravenes the 1974 Health Care Amendments which mandate that the Board avoid undue proliferation of bargaining units in the health care industry and 3) the Rule is arbitrary and capricious and is not supported by substantial evidence. The NLRB has filed a motion for summary judgment.[2]

I. BACKGROUND

A. *Legislative Enactments*

The Wagner Act (National Labor Relations Act of 1935, 29 U.S.C. secs. 151, *et seq.* (1935)), was enacted to pro-

[2] The Board asked this court to dismiss the AHA's complaint for lack of jurisdiction. The Board argued that the district court has no jurisdiction over a representation decision; section 9(d), 29 U.S.C. sec. 159(d), provides a specific mechanism for such review and any judicial review must take place in the court of appeals. We denied the Board's request for dismissal (oral ruling, May 19, 1989) because plaintiff does not ask us to determine the validity of representation under the new Rule, but questions the Board's authority to promulgate the rule. We are not foreclosed from review of the Board's rule-making authority. *American Medical Ass'n* v. *Weinberger*, 395 F.Supp. 515 (N.D. Ill.), *aff'd*, 522 F.2d 921 (7th Cir.-1975).

mote unionization and collective bargaining. After a time, Congress found that the Wagner Act unduly favored unions over companies and Congress passed the Taft-Hartley Act, amending the Wagner Act and creating a more balanced statutory scheme, while continuing the right of employees to be free from employer coercion. *See* C. Morris, *The Developing Labor Law* 437 (2d ed. 1983).

In 1974 Congress amended the Act to cover all private health care institutions, including not-for-profit hospitals.[3] Act of July 26, 1974, Pub.L. No. 93-360, 88 Stat. 395 (hereinafter "Health Care Amendments"). At this time Congress also recognized that labor regulation in the health care industry involves distinctive considerations. Patient treatment cannot tolerate interruption because health institutions provide care to the sick, the aged and the infirm. A disturbance in health care services is more serious than a break, for example, in industrial plant production. *See St. Vincent Hospital* v. *NLRB*, 567 F.2d 588, 590 (3rd Cir. 1977).

Ironically, the health care industry is particularly vulnerable to labor unrest. The industry is highly specialized and consists of many—frequently unrelated—professional and vocational specialties. Although only a few employees in each specialty may concentrate in a particular hospital, there is the potential for numerous job classifications and consequently the danger that collective bargaining units will proliferate. The greater the number of units, the

[3] Under the Wagner Act all hospitals were subject to federal regulation. The Taft-Hartley Act, however, exempted not-for-profit hospitals. In 1960, the Board included for-profit hospitals within the regulatory exemption, reasoning that hospitals were essentially local operations which did not operate in interstate commerce. *Flatbush General Hospital*, 126 NLRB 144 (1960). The Board reversed this exemption in 1967. *Butte Medical Properties*, 168 NLRB 266 (1967).

stronger the likelihood of labor unrest, which in turn jeopardizes the functioning of health care facilities. This is because the more units there are in a particular hospital, the fewer employees that have to agree to call a strike. *See NLRB* v. *Res-Care, Inc.*, 705 F.2d 1461, 1469 (7th Cir. 1983). Although it may be true that the smaller the unit the less critical an impact the strike will have, this may not be true in a health care institution where frequently each group of employees plays a significant role in the patient care and where the service cannot be prepared in advance. *Id.* Thus, the pattern of bargaining units organized in health care facilities has a considerable impact on the institutions.[4]

In order to protect the health care industry Congress included in the Health Care Amendments special provisions that lengthen the strike notice period and require federal mediation. NLRA sec. 8(d)(A)-(C), (g), 29 U.S.C. sec. 158(d)(A)-(C), (g). Congress, however, neither amended section 9 of the Act, 29 U.S.C. sec. 159, the provision which controls determination of bargaining units by the Board, to reflect their concern over proliferation of bargaining units, nor accepted a proposal by Senator Taft

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[4] One commentator notes with respect to the vulnerability of health care institutions to labor unrest:

> The numbers and types of units established can reasonably be expected to have an impact upon the incidence of labor disputes in health care institutions, and thus, upon the interruption of the delivery of services by such institutions, the costs of health care services, the administrative burden of managing health care institutions, the effectiveness of the organizational efforts of labor organizations and of their representation of employees, and the effectiveness of the collective bargaining process.

Bumpass, *Appropriate Bargaining Units in Health Care Institutions: An Analysis of Congressional Intent and Its Implementation by the National Labor Relations Board*, 20 B.C.L.Rev. 867, 868 n. 8 (1979).

which would have limited, by statute, the number of bargaining units to five (including guards) in non-profit health care institutions. S. 2292, 93 Cong., 1st Sess. (1973), *reprinted in, Legislative History of the Coverage of Non-profit Hospitals Under the National Labor Relations Act* at 457-58 (hereinafter "*Legis. Hist.*"). Instead, Congress, in both the House and Senate Committee Reports, expressed its concern by admonishing the Board to give due consideration "to preventing proliferation of bargaining units in the health care industry." Congress' statement was, in its entirety:

> EFFECT ON EXISTING LAW
>
> Bargaining Units
>
> Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1975 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).[1]

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[1] By our reference to *Extendicare*, we do not necessarily approve all of the holdings of that decision.

Legis. Hist., at 12, 274-275.

B. *Bargaining Unit Determinations*

Section 7 of the Act, 29 U.S.C. sec. 157 (1988), gives employees the right of self-organization. In the absence of an agreement between the employer and the employees, a union can obtain recognition for the purposes of collective bargaining by petitioning the Board under section 9

of the Act, and the Board must determine if employees in the petitioned-for unit form an appropriate bargaining unit.[5] Section 9(b) instructs the Board that an appropriate unit is one which will "assure to employees the fullest freedom in exercising the rights guaranteed by . . . [the] Act." The Act prevents the Board from using the "extent to which the employees have organized" as controlling in certifying election petitions. NLRA sec. 9(c)(5), 29 U.S.C. sec. 159(c)(5). The Act provides the Board with little other guidance in charging it to determine appropriate bargaining units for certification, thus the Board possesses broad discretion in this area. *Allied Chemical & Alkali Workers, Local No. 1* v. *Pittsburgh Plate Glass Co.*, 404 U.S. 157, 171-72, 92 S.Ct. 383, 393-94, 30 L.Ed.2d 341 (1971); *NLRB* v. *West Suburban Hospital*, 570 F.2d 213, 214 (7th Cir. 1978). Where, as here, a statute entrusts an agency with broad discretion to make decisions, a court will usually review the agency action under the deferential "abuse of discretion" standard. *NLRB* v. *Res-Care*, 705 F.2d 1461. Indeed, this is the standard generally used in unit determination cases. *Id.*

Unit determination requires that the Board weigh the competing interests of the employer and the employees. Employers seek few units with a greater number of workers presumably because many small units increase the likelihood of strikes and require repetitious bargaining, resulting in increased costs. If the units are too large, however, it impinges on the employees' right to union representation because too diversified a constituency may generate conflicts of interest and dissatisfaction within the

[5] Specifically, under NLRA sec. 9(b), 29 U.S.C. sec. 159(b) (1988), the Board must determine whether an "employer unit, craft unit, plant unit or subdivision thereof * * *" constitutes an appropriate bargaining unit.

group. *Id.* Generally, the Board's unit determinations are based on a "community of interest" standard.[6] C. Morris, *supra*, at 416-17. Under this principle employees with similar interests appropriately would be placed together for the purposes of collective bargaining. *See, e.g., In re Chrysler Corp.*, 1 NLRB 164, 169-70 (1936). Given the broad discretion permitted the Board, it would seem difficult for the courts to find fault with the community-of-interest standard. *Res-Care*, 705 F.2d at 1469. Nonetheless, in the fifteen years since the Health Care Amendments were enacted reviewing courts have tended to be less deferential to the NLRB's authority to make unit determinations when health care employees are at issue. *E.g., Mary Thompson Hospital, Inc.* v. *NLRB*, 621 F.2d 858, 864 (7th Cir. 1980) (because of Congressional admonition "Board must not rely exclusively on traditional community-of-interest analysis"). The court of appeals attributes their frequent rejection of the Board's orders to the Board's failure to properly consider Congress' admonition to avoid undue proliferation of bargaining units. *See, e.g., NLRB* v. *HMO Int'l/California Medical Group Plan, Inc.*, 678 F.2d 806, 808 (9th Cir. 1982); *Beth Israel Hosp. & Geriatric Center* v. *NLRB*, 677 F.2d 1343, 1345 (10th Cir. 1981); *cert. denied*, 459 U.S. 1025, 103 S.Ct. 433, 74 L.Ed.2d 522 (1982); *Presbyterian/St. Luke's Medical Center* v. *NLRB*, 653 F.2d 450, 455 (10th Cir. 1981), *cert. denied*, 459 U.S. 1025, 103 S.Ct. 433, 74 L.Ed.2d 522 (1982); *NLRB* v. *Mercy Hosp. Ass'n*, 606 F.2d 22 (2nd Cir. 1979), *cert. denied*, 445 U.S. 971, 100 S.Ct. 1665, 64

[6] Under the "community-of-interest" standard an appropriate bargaining unit is identified by the following characteristics: similarity of wages and hours, extent of common supervision, frequency of contact with other employees, and area practice and patterns of bargaining. *Allegheny General Hospital*, 239 NLRB 872, 873 (1978), *enf. denied on other grounds*, 608 F.2d 965 (3rd Cir. 1979).

L.Ed.2d 248 (1980); *NLRB* v. *St. Francis Hosp.*, 601 F.2d 404 (9th Cir. 1979); *NLRB* v. *West Suburban Hosp.*, 570 F.2d 213 (7th Cir. 1978); *St. Vincent's Hosp.* v. *NLRB*, 567 F.2d 588 (3d Cir. 1977).

In response to judicial criticism, in 1982 the Board introduced a new two-tiered approach for bargaining unit determination on health care, *St. Francis Hospital*, 265 NLRB 1025 (1982) (hereinafter "*St. Francis I*"). First, the Board would determine if the petitioned-for unit was one of the seven units identified as "potentially appropriate" (physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and skilled maintenance employees). Second, the Board determined whether a community of interest existed among the employees in the unit and if it did the unit would be approved. A unit which did not coincide with any of the seven categories would be approved only in extraordinary circumstances. *Id.* at 1029.

When the hospital refused to bargain with the prevailing union in the unit approved in *St. Francis I*, the Board re-evaluated its two-tier approach in light of the judicial criticism of the community-of-interest approach. *St. Francis Hospital*, 271 NLRB 948 (1984) (hereinafter "*St. Francis II*"). The NLRB adopted a "disparity-of-interest" test which, the Board asserted, took better account of the Congressional Admonition against undue proliferation.[7] The Board expressly indicated that it adopted this approach because it avoided a rigid standard which

[7] A unit will be approved under the disparity-of-interest test if there exists "sharper than usual differences (or disparities) between wages, hours, and working conditions, etc., of the requested employees and those in an overall professional or nonprofessional unit." *St. Francis II*, 271 NLRB at 953.

would be inappropriate for the "diverse nature of today's health care industry", *id.* at 953 n. 39, and thus would comport "with Congress' intent that the Board be free to exercise flexibility in dealing with unit determinations on a case-by-case basis." *Id.* at 951 n. 17.

The Court of Appeals for the District of Columbia reversed *St. Francis II*, holding that while the disparity-of-interest standard was permissible under the Act, it was not a required interpretation and remanded the case to the Board for further explanation. *IBEW, Local Union 474* v. *NLRB*, 814 F.2d 697, 708 (D.C. Cir. 1987). The NLRB accepted remand, but rather than seeking further review or explicating its disparity-of-interest approach, the Board announced its intent to invoke its section 6 rule-making authority and finally resolve the issue of appropriate bargaining units in the health care industry. *St. Francis Hospital*, 286 NLRB No. 123 (1987). *See also St. Vincent Hospital*, 285 NLRB No. 64 (1987). This litigation is the result of the Board's decision to determine unit appropriateness by rule-making.

C. *The Rule-Making*

On July 2, 1987, the Board published a Notice of Proposed Rulemaking and Hearing, explaining that it intended "to amend its rules to include a new provision specifying which bargaining units will be found appropriate in various types of health care facilities." Notice of Proposed Rulemaking, July 2, 1977, 52 Fed.Reg. 25142-49 (hereinafter "NPR I"). The Board indicated that it was abandoning its unsuccessful doctrinal approaches and would gather empirical evidence in order to make "an informed judgment as to what types of units should be found appropriate in the health care industry." NPR I, 52 Fed.Reg. 25144. In NPR I the Board proposed that

in large acute care hospitals with more than 100 beds six units (registered nurses, physicians, technical employees, service and maintenance and clerical employees except guards, and guards) would be appropriate. *Id.* at 25149.[8] Following the publication of NPR I the Board gathered testimony and comments on the proposed rules.

On September 1, 1988, the Board published a Second Notice of Proposed Rulemaking (NPR II), 52 Fed.Reg. 33900-33935. In NPR II the Board abandoned the large-small hospital distinction and removed nursing homes and psychiatric hospitals from the scope of the proposed rule. NPR II, Fed.Reg. 33927-30. The Board also divided the service maintenance and clerical unit into three separate units consisting of skilled maintenance workers, business office clericals and service and other non-professional employees. *Id.* at 33920-27.

On April 21, 1989, the Board published the Final Rule. 29 C.F.R. Part 103, 54 Fed.Reg. 16336-48 (the "Rule"). Under the Rule the eight bargaining units proposed in NPR II would be the only units appropriate for collective bargaining in an acute care hospital, absent extraordinary circumstances. The Rule provides for a substantial departure from the method the Board used to make unit determinations over the last fifty years. The Board indicated that it deliberately chose to make the eight units determinative of appropriateness and not presumptively appropriate "because one important advantage of rule-making is the certainty it offers." NPR I, 52 Fed.Reg. 25145. The Board added that rules are more effective than rebuttable presumptions to resolve their concern with

[8] In nursing homes and smaller hospitals the number of appropriate units would be limited to four. These were: all professional employees, all technical employees, all service, maintenance and clerical employees except guards, and all guards.

duplicative litigation. Final Rule, 54 Fed.Reg. 6338-39. The Board justifies its action by stating that in its experience "facilities and employee functions in hospitals and other health care institutions of approximately the same size and type are virtually identical." NPR I, Fed.Reg. 25145.

Although the Board leaves an opportunity for a hospital to remove itself from the general applicability of the rules by claiming an "extraordinary circumstance"[9], the Board has signaled its intent to construe this exception narrowly "so that it would not provide an excuse, opportunity or 'loophole' for redundant and unnecessary litigation. . . ." NPR II, 52 Fed.Reg. 33923. Consequently, the Board enumerates several broad categories of concerns a hospital might advance to remove itself from the general applicability of the Rule which will not be considered. These issues, according to the Board, were addressed during the rule-making process, found not to affect a unit determination, and therefore, would not qualify for litigation under the extraordinary circumstance exception.[10] In any event,

[9] The Rule enables a facility claiming an extraordinary circumstance to present an offer of proof to a hearing officer who will either permit the evidence to be adduced or refer the offer to the Regional Director, or if requested, the Board. If it is determined that an extraordinary circumstance does not exist, the hospital can seek judicial review.

The Board does note that an extraordinary circumstance which will remove a unit from automatic coverage by the Rule is a petition for a unit comprised of five or fewer employees. Final Rule, 54 Fed.Reg. 16346.

[10] According to the Board the following issues have already been considered and will not be subject to further litigation with respect to unit determinations:

> . . . arguments relating to (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of out-patient services provided, and differing staffing patterns among facil-

(Footnote continued on following page)

the Board concludes that the rule reflects a natural and realistic grouping found in the health care industry and once the rule is in effect "no other unit will be found appropriate by the Board absent extraordinary circumstances."[11]

The AHA believes these rules are invalid and sues for injunctive relief. The NLRB defends its new Rule and seeks summary judgment in its favor.

II. ANALYSIS

The AHA's complaint questions the scope of the Board's rulemaking authority under section 6 of the NLRA, in

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[10] *continued*

ities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multicompetent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nation-wide hospital "chains"; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building. Except as specifically noted elsewhere (e.g., exclusion of psychiatric hospitals and nursing homes from coverage by the rule), the Board has concluded that none of the arguments raised in the course of the rulemaking procedure, including those listed above, alone or in combination, constitutes an "extraordinary circumstance" justifying an exception from the rule.

NPR II, 53 Fed.Reg. 33932 (footnote omitted).

[11] Board member Wilford W. Johansen dissented from the Board's decision to establish bargaining units through its rulemaking procedure. He stated that rule-making was foreclosed by section 9(b) and furthermore, in this context is "at best inadvisable." Final Rule, 54 Fed.Reg. 16347.

light of section 9(b), and in the particular context of the health care industry. Section 9(b) provides:

> The Board shall decide *in each case* whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit or subdivision. . . . (Emphasis added.)

The AHA contends that the "in each case" language mandates that the Board make an individualized determination of appropriate bargaining units based on the particular facts of each case presented to the Board. The AHA says that the NLRB's new Rule pre-determines appropriate bargaining units, and thus, obviates the case-by-case review called for by 9(b). The Board, with its best argument, concedes that perhaps 9(b) contemplates that the Board will make a unit determination in each case in which a petition for a representation election is filed. Even so, the Board argues, 9(b) does not preclude the Board from promulgating general rules and regulations applicable to unit determination, pursuant to their section 6 power.

Congress afforded the Board broad discretion under section 9 of the Act to determine appropriate employee units for the purposes of collective bargaining. *IBEW, Local No. 474*, 814 F.2d at 699. We will not, however, sustain a use of this discretion if it is based on the Board's erroneous understanding of the statute. *Id.* (quoting *Prill* v. *NLRB*, 755 F.2d 941, 947 (D.C.Cir.), *cert. denied*, 474 U.S. 948, 106 S.Ct. 313, 88 L.Ed.2d 294 (1985). *Accord Ford Motor Co.* v. *NLRB*, 441 U.S. 488, 99 S.Ct. 1842, 60 L.Ed.2d 420 (1979).

A. *Judicial Review*

The starting point for any judicial interpretation of a statute must be the language of the statute itself and if

"we find the terms of a statute unambiguous, judicial inquiry is complete." *In re Sinclair*, 870 F.2d 1340, 1341 (7th Cir. 1989) (quoting *Rubin* v. *United States*, 449 U.S. 424, 430, 101 S.Ct. 698, 701, 66 L.Ed.2d 633 (1981)). *See also Lewis* v. *United States*, 445 U.S. 55, 60, 100 S.Ct. 915, 918, 63 L.Ed.2d 198 (1980). This dispute rests on the meaning of the words "in each case." These words are not necessarily inconsistent with the Board's attempt to promulgate industry-wide rules, unless there is some indication that Congress required fact specific determinations in each case. We cannot rely simply on the plain meaning of 9(b) to determine the limitations the statute imposes on the Board's section 6 rule-making authority. When the words of a statute are vague, so that a resolution cannot be gleaned from the words of the text, we must determine which interpretation "would best advance the legislative purpose." *Virtual Network Services* v. *United States*, 98 B.R. 343, 345 (N.D.Ill. 1989) (quoting *Mechmet* v. *Four Seasons Hotels, Ltd.*, 825 F.2d 1173, 1175 (7th Cir. 1987)).

The NLRB suggests that because the text of the statute offers no determinative guidance, we are obligated to give deference to an agency interpretation which is based on a permissible construction of the statute. *Chevron U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 2781-82, 81 L.Ed.2d 694 (1984). *Accord NLRB* v. *United Foods & Commercial Workers Union*, 484 U.S. 112, 108 S.Ct. 413, 421, 98 L.Ed.2d 429 (1987). But deference is due the agency only if its interpretation is rational and consistent with the statute. *Beth Israel Hospital* v. *NLRB*, 437 U.S. 483, 501, 98 S.Ct. 2463, 2473, 57 L.Ed.2d 370 (1978). *Accord Public Employees Retirement System of Ohio* v. *Betts*, ___ U.S. ___, ___, 109 S.Ct. 2854, 2863, 106 L.Ed.2d 134 (1989) (no deference due agency interpretation at odds with the

language of the statute itself); *SEC* v. *Chenery Corp.*, 332 U.S. 194, 196, 67 S.Ct. 1575, 1577, 91 L.Ed. 1995 (1947) (administrative order cannot be upheld unless the grounds upon which agency acted in exercising its powers were those upon which its action can be sustained). We refuse the Board's invitation to defer to their interpretation of 9(b).[12] Although the language of the statute is not definitive, it does shed doubt on the extent of the Board's authority.

It is not within our province to determine whether the AHA's or the NLRB's interpretation of 9(b) is best suited for the health industry. The political branches engage in a deliberate process to arrive at text which becomes law. *In Re Sinclair*, 870 F.2d at 1344. We must abide by their pronouncements. Legislative history, although it is not "a source of legal rules competing with those found in the U.S. Code . . ." may help "us learn what Congress meant by what it said." *Id.* So, because the words of the statute do not lend a definitive answer with respect to the scope of the NLRB's rule-making authority under 9(b) and because the NLRB's Rule may in fact be inconsistent with the "in each case" language, we must examine Congress' purpose.

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[12] Consideration must also be given to the consistency with which the NLRB has interpreted a statute. Prior to the Rule, for over fifty years, the Board's policy was to make bargaining unit determinations through administrative review of each petition, because, as the Board noted in *St. Francis Hospital*, 271 NLRB 948, 951 n. 17 (1984), Congress intended that it "exercise flexibility in dealing with the unit determinations on a case-by-case basis." When, as here, an administrative agency vacillates in its interpretation of an authorizing statute, its interpretation is entitled to little deference. *NLRB* v. *United Food and Commercial Workers Union*, 484 U.S. 112, 108 S.Ct. at 421 n. 20; *County of Washington* v. *Gunther*, 452 U.S. 161, 177-78, 101 S.Ct. 2242, 2251-52, 68 L.Ed. 2d 751 (1981).

B. *Rule-Making Authority Under Section 9(b)*

The AHA and the Board agree that it is indicative of Congressional intent that the original texts of the Senate and House Bills did not contain the "in each case" language. *See* Senate Bill 1958, 74th Cong., 1st Sess., *reprinted in*, I *Legislative History of the National Labor Relations Act 1935*, at 1300 (1949) (hereinafter "____ *1935 Legis. Hist.*, at ____"); House Bill H.R. 6187 and 6288, 74th Cong., 1st Sess., *reprinted in*, II *1935 Legis. Hist.*, at 2449, 2464. Later, House Bill H.R. 7978 was introduced which included the "in each case" language, and the Senate Bill was amended to conform to the H.R. 7978. The amendment was accepted by the House-Senate Committee. *See* II *1935 Legis. Hist.*, at 3253-54. The parties do not agree, however, on the implications of Congress' addition. The AHA says the language clearly signals Congress' intent that bargaining unit determinations should be made by the Board on a case-by-case basis. As support the AHA cites to the House Labor Committee Report on H.R. 7978 which explains:

> Section 9(b) provides that the Board shall determine whether, in order to effectuate the policy of the bill (as expressed in sec. 1), the unit appropriate for the purposes of collective bargaining shall be the craft unit, plant unit, employer unit or other unit. *This matter is obviously one for determination in each individual case*, and the only possible workable arrangement is to authorize the impartial governmental agency, the Board, to make that determination.

H.R.Rep. No. 969, 74th Cong., 1st Sess. (1935), *reprinted in* II *1935 Legis. Hist.*, at 2930 (emphasis added).

The Board contends that the amendment was just a house-cleaning detail and refers to Labor Secretary Perkins' comment that "in each case" was only one of several small amendments "made for the sake of clarity."

I *1935 Legis. Hist.*, at 1442. According to the Board the statement in the Committee Report, cited by plaintiff, followed a discussion of which entity should make unit appropriateness decisions—the employer, the union or the government agency—and that therefore, the only significance of the words "in each case" is that unit determination will be the function of the Board.

We must adopt the AHA's view of the Congressional intent for several reasons. First, the Board has failed to show that even if the amendment was small and only for the sake of clarity it is inconsistent with Congressional intent that unit determinations should be on an individual basis. In any event, Secretary Perkins' understanding of the amendment carries little weight, no significance is to be accorded statements made by nonmembers in a Congressional hearing. *See Kelly* v. *Robinson*, 479 U.S. 36, 107 S.Ct. 353, 361-62 n. 13, 93 L.Ed.2d 216 (1986). On the other hand, the explanation in the House Report, a persuasive indicia of Congressional intent, provides compelling support that Congress contemplated that unit determinations would require fact specific inquiries. *See Mills* v. *United States*, 713 F.2d 1249, 1252 (7th Cir. 1983), *cert. denied*, 464 U.S. 1069, 104 S.Ct. 974, 79 L.Ed.2d 212 (1984) (generally, the committee report is "the most persuasive indicia of Congressional intent (with the exception, of course, of the language of the statute itself)").

The Board's explanation that the House Report simply emphasizes that the Board is to make the unit determination is less plausible, we do not see how the words "in each case" serve to reiterate the Board's authority. If we were to accept the Board's construction, the words "in each case" become superfluous in the context of section 9(b), merely repeating Congress' charge to the Board in the preceding phrase. We hesitate to condone such a result. *Zimmerman* v. *North American Signal Co.*, 704

F.2d 347, 353 (7th Cir. 1983) ("[a]s a general rule, a court should not construe a statute in a way that makes words or phrases meaningless, redundant, or superfluous.").

Finally, an important and obvious rule of statutory construction is that a particular statutory phrase should not be construed in isolation but with reference to the statute as a whole. *United States* v. *Morton*, 467 U.S. 822, 828, 104 S.Ct. 2769, 2773, 81 L.Ed.2d 680 (1984). One purpose of the NLRA is to provide employees with the right to bargain collectively, section 9(b) states specifically that the Board's unit determination must "assure to employees the fullest freedom in exercising the rights guaranteed." It is fair to say that an individualized determination of bargaining units appropriate in a particular institution or facility will better assure employees the "fullest freedom in exercising . . . [their] rights." Although the language "in each case" may not plainly indicate Congress' purpose, the fairer and more plausible interpretation is that Congress believed that for collective bargaining to fulfill the purpose for which it was meant, unit appropriateness should be considered by the Board on a case-by-case basis.

The AHA tells us that if we find that 9(b) contemplates individualized bargaining unit determinations, we must find the Board's Rule invalid. We disagree. The AHA still falls short of victory. The fact that the NLRB is statutorily bound to make determinations which are tailored to individual cases is not necessarily inconsistent with the Board's use of its section 6 rule-making authority. It would be a misuse of resources to prevent the Board from using fact gathering apparatus to develop principles applicable to recurring scenarios. It defies common sense to believe Congress would entrust unit determination to the Board under section 9 because of its experience and expertise, and then, simultaneously require it to face each

contested case *ab initio*. Indeed, there are persuasive arguments to encourage the Board to take advantage of its rule-making authority.[13] Peck, *The Atrophied Rule-Making Powers of the National Labor Relations Board*, 70 Yale L.J. 729 (1961). Of course, there are equally compelling arguments that case-by-case adjudication is more appropriate to the Board's function. Although it may be cumbersome, case-by-case review is more amenable to the unique circumstances of employers and employees in diverse settings, and perhaps, a necessary burden for a labor policy which will extend to employees the fullest freedom to exercise their rights.

For our purposes in this litigation, however, it is sufficient to conclude that the Board is not foreclosed from rule-making in fulfilling its 9(b) charge. A definitive decision concerning the limitations on the Board's general rule-making authority with respect to bargaining unit ap-

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[13] One inherent advantage of using substantive rules is the consistency they provide. If the Board articulates clear labor policy through rule-making then the people will know what the law requires and the extent of their rights. Rule-making advances policy which can be applied uniformly by Board representatives, whereas case-by-case adjudication, even when rules derived by adjudication are applied, emphasizes only the facts before the Board, thus giving rise to haphazard policy and disparate treatment of parties. Bernstein, *The NLRB's Adjudication-Rule Making Dilemma Under the Administrative Procedure Act*, 79 Yale L.J. 571, 590-91 (1970) ("[r]ulemaking provides the agency with the opportunity to initiate changes in its own doctrine whereas adjudication leaves the initiative to the few private parties who have the resources, the hardheadedness, or the the innocence to persevere in the litigation process"). The Board's ability to act on particular matters is limited to the controversies brought to its attention, only its rule-making authority and the procedures outlined in the APA enable the Board to gather diverse and informed opinions and gain a broader overview of the reality of the workplace. *See Morris, The NLRB in the Dog House—Can an Old Board Learn New Tricks?*, 24 San Diego L.Rev. 9 (1987).

propriateness can be left for another day. This case presents a far narrower issue: the extent of the Board's rule-making authority under 9(b) in the context of the health care industry. This changes the nature of the inquiry. Both the legislative and judicial branches have recognized health care as a unique and complex industry, and as discussed above, generally applicable standards frequently have been revised or even rejected when applied in the context of the health care field. *See e.g., Mary Thompson Hospital* v. *NLRB*, 621 F.2d 858, 864 (7th Cir. 1980).

C. *Congress' Admonition Against Undue Proliferation*

The stakes are higher when the Board makes bargaining unit determinations in the health care field; fragmentation of the workforce is more likely and of greater concern when patient care is at issue. Congress drew attention to the distinctive vulnerability of health care by enacting amendments to the NLRA in 1974 and, particularly, by stating in both the Senate and House committee reports that the Board should avoid undue proliferation of bargaining units in the health care industry. Much authority has been given to this admonition and many circuits have reversed the Board for failing to give proper credence to the Congress' expressed concern. Although a number of circuit court judges have questioned how much weight the committees' statement should be given, *Res-Care*, 705 F.2d at 1470 (Posner, J.); *IBEW, Local 747*, 814 F.2d at 712 (Edwards, J.), the Seventh Circuit, and others, have treated the statement as authoritative. *See, e.g., Res-Care*, 705 F.2d at 1470; *NLRB* v. *West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978).

1.

The question of how much proliferation is undue has not been resolved in this circuit. *Res-Care*, 705 F.2d at 1470. An absolute answer to this question is not required to conclude that the Board's Rule will create undue proliferation. Suffice it to say, that it is evident that the Board has failed to give "more than mere lip service mention of the Congressional admonition", *NLRB* v. *West Suburban Hospital*, 570 F.2d at 216, when it promulgated its new Rule. The Rule mandates *automatic* fragmentation of the workforce into eight units, without regard to the nature and extent of the health services rendered or the dynamics of a particular health care institution.[14]

The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) and the Building and Construction Trades Department note that proliferation is but one factor that the Board must take into account when it makes unit determinations and while the rule may implicate the proliferation concern, other factors, such as section 9(b)'s directive to assure employees the fullest freedom in bargaining, must also be factored into the Board's decision. Congress only required the Board to give proliferation "due consideration" and it was not an abuse of discretion for the Board to establish the units

[14] When Congress was in the process of making changes to the Act in 1974, Senator Taft proposed a bill that he intended would prevent proliferation by statutorily designating only five permissible bargaining units in the health care institutions. *1974 Legis. History*, at 106-12. The AHA argues that Congress' rejection of that Bill is conclusive evidence that Congress did not envision pre-determined units. We are not convinced, and this is not how we reach the decision that pre-determined units do not prevent proliferation. A plausible reading of Congress' refusal to statutorily determine bargaining units would also be that the House and Senate believed that the agency which Congress had authorized to make these decisions had more expertise to do so.

in the Rule if they accommodated other Congressional concerns. Although a compelling argument, this is not the way we understand the policy against proliferation.

There are general directives which the Board must follow whenever it makes a unit appropriateness decision in whatever the industry. But Congress drew attention to health care by adding another concern, which must be addressed by the Board in certifying bargaining units in that industry. We understand this to mean that when the Board takes action or crafts policy with respect to bargaining units involving health care employees, it must use the means least likely to cause unit proliferation to achieve their objective. Although we can agree with the Board that the eight units they establish are appropriate and in many instances may match the natural divisions among the employees in health care institutions, we can envision other divisions, perhaps fewer divisions, in the varied health institutions which would be equally reasonable.

2.

In its defense the Board argues that the Rule is functionally no different than adjudicated rules of general applicability which the Board has relied on with judicial approval. *National Labor Relations Board* v. *Metropolitan Life Insurance Co.*, 380 U.S. 438, 443 n. 6, 85 S.Ct. 1061, 1064 n. 6, 13 L.Ed.2d 951 (1967) (affirming Board's authority to determine appropriateness of different bargaining units by decisions of general applicability). Adjudicated rules develop where a principle established in one case is applied to subsequent representation cases to determine appropriate bargaining units. *See, e.g., Big Y Foods* v. *NLRB*, 651 F.2d 40, 45 (1st Cir. 1981) (presumption that separate meat department is appropriate); *NLRB* v. *New Enterprise Stone & Lime Company*, 413 F.2d 117,

118 (3rd Cir. 1969) (separate warehouse unit appropriate where three conditions are met).

From the onset these cases are distinguished because not one of the cases cited by the Board involves unit determination in the health care industry. Thus, the express policy against proliferation has no bearing in these cases. In addition, rule-making by adjudication is fundamentally different than a rule promulgated under the APA procedures, because an adjudicated rule evolves only in context where parties have litigated their unique concerns and can only be applied in a similar context. An adjudicated rule may be adapted to factual distinctions, whereas the Board's rule which predetermines units, necessarily ignores differences which, although the Board refers to them as subtle, may be the key to labor peace.[15]

Similarly misplaced is the Board's reliance on *Heckler* v. *Campbell*, 461 U.S. 458, 103 S.Ct. 1952, 76 L.Ed.2d 66 (1983). In *Heckler* the Supreme Court upheld the Secretary's use of medical-vocational guidelines, developed by

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[15] We do not rely on *NLRB* v. *Wyman-Gordon*, 394 U.S. 759, 89 S.Ct. 1426, 22 L.Ed.2d 709 (1969), where the Court notes that adjudicated precedent "guides future conduct in much the same way as though it were a new rule promulgated under the rule-making power." *Id.* at 771, 89 S.Ct. at 1432 (Black, J., concurring). The Supreme Court does not, as defendant argues, endorse rule-making, but criticizes the Board for using adjudication where rule-making and the procedures of the APA are authorized. Furthermore the Supreme Court's comments are not in the context of unit determinations.

Nor do we rely on *NLRB* v. *Metropolitan Life Insurance Co.*, 380 U.S. 438, 443 n. 6, 85 S.Ct. 1061, 1064 n. 6, 13 L.Ed.2d 951 (1965) where the Court noted "the Board may articulate the basis of its [unit determination] order by reference to other decisions and to general policies laid down in its rules. . . ." This reference is *dicta*, however, and only endorses the view that in appropriate circumstances the Board will not be barred from using its section 6 rule-making authority.

rule-making, to determine a claimant's right to disability benefits, although the Social Security Act contemplates individualized hearings. *Heckler* is distinguishable. The individualized review of the claimant's case is not obviated by the Secretary's rules, because a hearing is required to determine the claimant's particular limitations and abilities before the Secretary can even use the guidelines. The determination of whether a job exists for a claimant once his or her particular qualifications are assessed, is no longer a question subject to factual distinctions, *Heckler*, 461 U.S. at 467, 103 S.Ct. at 1957, unlike the determination of unit appropriateness which depends on the dynamics of a specific health care institution. Finally, the Secretary does not claim any medical expertise and the guidelines replace the Secretary's reliance on a vocational expert. The Board's primary function and expertise, however, is supervising labor relations.

The AFL-CIO argues that preconceived determinations are inescapable, because as a practical matter the representation process could not function if the Board did not identify particular employee groups which constitute appropriate units. Employees must be aware of the Board's policy to exercise their right of self-organization and employers must also, to properly respond to representation claims. Thus, the AFL-CIO implies the Rule establishes, more expeditiously and less disengeniously [sic], what the NLRB must do anyway. We agree, for representation procedures to function certain principles must be presumed. But these principles are more analogous to guidelines or rebuttable presumptions than to rules. Rule-making is inherently less flexible which means that health care employees will be encouraged, or perhaps even coerced, by the Rule to organize according to the eight established units even in facilities where such fragmentation is un-

necessary.[16] And, without a doubt, this result does not prevent undue proliferation.[17]

III. CONCLUSION

In sum, we find, that section 9(b) of the NLRA does not entirely foreclose the Board from promulgating rules with respect to appropriate collective bargaining units. Congress, however, enunciated a specific concern for the vulnerability of the health care industry to labor unrest. In light of this vulnerability Congress admonished the Board to give due consideration to undue proliferation of bargaining units in this industry. A rule which designates an absolute number of appropriate units and mandates a particular division of the workforce, especially in the health care field where employees' work environment varies widely, is not responsive to Congress' express con-

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[16] For the last fifteen years the Board has explored several alternatives to establish a coherent policy for unit determination in the health care industry. The Board has been frequently criticized by the judiciary and accused of pursuing an erratic course. The Board's attempt to establish concrete policy through their rule-making authority may be laudable. Yet the simple fact that the Board was unable to develop criteria for unit determination without raising judicial concern in particular cases, where one health care institution was at issue, should have been indicative of the difficulties of a rigid, generally applied policy in a field where the institutions are so diverse.

This is not to say that a combination of rule-making and adjudication could not be beneficial. Rule-making could provide guidelines which facilitate representation for all parties (unions, employers and employees) yet leave room for adjudication to consider the particular dynamics of a hospital or other health care facility.

[17] Because we find that the Board's Rule is inconsistent with the policy against proliferation of bargaining units in the health care industry, we need not address AHA's argument that the new Rule is arbitrary and capricious.

cern. In fact, as noted above, such a rule encourages, and perhaps coerces, fragmentation of the labor force within particular health care facilities.

A permanent injunction will issue where the plaintiff succeeds on the merits and if the balance of equities favors injunctive relief. For the reasons stated above the AHA has succeeded on the merits of its claim. The unique concerns in the health care industry favor injunctive relief. The appropriate remedy is to permanently enjoin the NLRB's Final Rule, 29 C.F.R. Part 103, establishing bargaining units in the health care industry, from taking effect.

The NLRB's Motion for Summary Judgment is denied and the petitions to intervene of the AFL-CIO, the Building and Construction Trades Department and the American Nurses' Association are granted.[18]

SO ORDERED.

[18] The AFL-CIO, the Building and Construction Trades Department and the American Nurses' Association (the "ANA") sought to intervene as defendants. We found that they were not intervenors as of right (oral ruling, May 19, 1989). At that time we granted the AFL-CIO, the Building and Construction Trades Department and the ANA *amici* status and continued their Motion for Permissive Intervention. We now grant them status as permissive intervenors, pursuant to Fed.R.Civ.P. 24(b).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 9(b) of the National Labor Relations Act, 29 U.S.C. § 159(b), provides:

> The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof: *Provided*, That the Board shall not (1) decide that any unit is appropriate for such purposes if such unit includes both professional employees and employees who are not professional employees unless a majority of such professional employees vote for inclusion in such unit; or (2) decide that any craft unit is inappropriate for such purposes on the ground that a different unit has been established by a prior Board determination, unless a majority of the employees in the proposed craft unit vote against separate representation or (3) decide that any unit is appropriate for such purposes if it includes, together with other employees, any individual employed as a guard to enforce against employees and other persons rules to protect property of the employer or to protect the safety of persons on the employer's premises; but no labor organization shall be certified as the representative of employees in a bargaining unit of guards if such organization admits to membership, or is affiliated directly or indirectly with an organization which admits to membership, employees other than guards.

The National Labor Relations Board's Final Rule for Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16347-16348, 29 C.F.R. § 103.30, provides:

> § 103.30 Appropriate bargaining units in the health care industry.
>
> (a) This portion of the rule shall be applicable to acute care hospitals, as defined in paragraph (f) of

this section: Except in extraordinary circumstances and in circumstances in which there are existing nonconforming units, the following shall be appropriate units, and the only appropriate units, for petitions filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that, if sought by labor organizations, various combinations of units may also be appropriate:

(1) All registered nurses.

(2) All physicians.

(3) All professionals except for registered nurses and physicians.

(4) All technical employees.

(5) All skilled maintenance employees.

(6) All business office clerical employees.

(7) All guards.

(8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards. *Provided That* a unit of five or fewer employees shall constitute an extraordinary circumstance.

(b) Where extraordinary circumstances exist, the Board shall determine appropriate units by adjudication.

(c) Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed pursuant to sec. 9(c)(1)(A)(i) or 9(c)(1)(B), the Board shall find appropriate only units which comport, insofar as practicable, with the appropriate unit set forth in paragraph (a) of this section.

(d) The Board will approve consent agreements providing for elections in accordance with paragraph (a) of this section, but nothing shall preclude regional directors from approving stipulations not in accordance with paragraph (a), as long as the stipulations are otherwise acceptable.

(e) This rule will apply to all cases decided on or after May 22, 1989.

(f) For purposes of this rule, the term:

(1) "Hospital" is defined in the same manner as defined in the Medicare Act, which definition is incorporated herein (currently set forth in 42 U.S.C. 1395x(e), as revised 1988);

(2) "Acute care hospital" is defined as: either a short term care hospital in which the average length of patient stay is less than thirty days, or a short term care hospital in which over 50% of all patients are admitted to units where the average length of patient stay is less than thirty days. Average length of stay shall be determined by reference to the most recent twelve month period preceding receipt of a representation petition for which data is readily available. The term "acute care hospital" shall include those hospitals operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, psychiatric care, or rehabilitative care, but shall exclude facilities that are primarily nursing homes, primarily psychiatric hospitals, or primarily rehabilitation hospitals. Where, after issuance of a subpoena, an employer does not produce records sufficient for the Board to determine the facts, the Board may presume the employer is an acute care hospital.

(3) "Psychiatric hospital" is defined in the same manner as defined in the Medicare Act, which definition is incorporated herein (currently set forth in 42 U.S.C. 1395x(f)).

(4) The term "rehabilitation hospital" includes and is limited to all hospitals accredited as such by either Joint Committee on Accreditation of Healthcare Organizations or by Commission for Accreditation of Rehabilitation Facilities.

(5) A "non-conforming unit" is defined as a unit other than those described in paragraphs (a)(1) through

(8) of this section or a combination among those eight units.

(g) Appropriate units in all other health care facilities: The Board will determine appropriate units in other health care facilities, as defined in section 2(14) of the National Labor Relations Act, as amended by adjudication.
